

Comprehensive School Health: An Ethnographic Case Study

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## ABSTRACT

The purpose of this ethnographic case study was to describe the characteristics of one school's Comprehensive School Health (CSH) initiative and to explore the experiences of school community members in order to gain an understanding of how one school embraced a Comprehensive School Health approach. An elementary school (grades Junior Kindergarten to six) in Burlington, Ontario was the research site for this study. Multiple methods of data collection (observations, document analysis, interviews) were used in keeping with the ethnographic and case study approach. The data were coded using both a deductive and then inductive process (Merriam, 1998). From a deductive perspective, the coding system and the subsequent identification of categories were based on a priori categories identified by using the elements of CSH based on the Comprehensive School Health Consensus Statement prepared by the Canadian Association of School Health and the research questions. Findings included the role that various school community members as well as the implementation of different programs and policies played in applying a CSH approach. The impact of the physical environment was described as well as successes and challenges related to the school's experience in implementing CSH. Three main themes emerged that characterized this school's experience. The first theme relates to the fundamental question about CSH which is the school community's *understanding of the concept*. The second theme focused on *positive school culture* and the third and most diverse theme was that of *capacity*. Engaging in CSH is a complex and long-term undertaking involving both the school and greater community. Based on the experiences of this school's community members, recommendations address the different levels of influence on the health of children.

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## CHAPTER 1

### INTRODUCTION

Health is a subject that dominates our lives. It is a source of casual conversation and heated debate. Health and the issue of health care define us as Canadians. Yet there are likely as many definitions of health as there are people and cultures. The definition adopted for this study is that developed by the World Health Organization (WHO) which states:

To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (World Health Organization, 1986, p. 1)

There are two key ideas in this quote that are seminal to this research. First, health is a fundamental resource for living. Rather than an additional and seemingly elusive task on one's daily list of things to do, health is the foundation upon which a person can build a fulfilling life, rich with possibilities, striving not just for length but also for breadth. The word "foundation" implies a basis or underpinning for all things to come. In the case of health, then, lifelong health must have its basis in childhood, a critical beginning in which to create and ingrain healthy lifestyles and other aspects of well being as a natural part of every aspect of daily life and supported in all environments.

The promotion of health must be embraced by all sectors of society, not just the health sector – the second significant idea in this quote. The health (or health care) sector is mainly comprised of organizations and institutions that deliver sickness care and should, therefore, be viewed as the end of the health continuum rather than as the beginning.

As a society, it behooves us to embrace a preventative approach to health by ensuring that all sectors are identifying and supporting the innumerable opportunities to teach and support health and well-being. One key sector that provides an opportunity to address such issues is the education sector. In particular, the WHO has identified the education of children and youth as a critical target.

Health is inextricably linked to educational achievements, quality of life and economic productivity. By acquiring health-related knowledge, values, skills, and practices, children can be empowered to pursue a healthy life and to work as agents of change for the health of their communities. (Dr. Hiroshi Nakajima, Director-General World Health Organization, 1997, p. 1)

While schools alone cannot assume the responsibility for combating health and social problems without the support and participation of families and community partners (e.g., health professionals, media, religious institutions and local governments), they can provide an important setting through which these organizations and individuals can work together for the promotion of health and well being of all community members (Centers for Disease Control, 2005). According to Ronson and MacDougall (2003), schools, next to family, exert the most influence on children; they are the workplace of 20% of our

population (students, teachers and staff); and they directly involve another 30% of the population (parents) with the school and the children.

Since 1950, with the establishment of an Expert Committee on School Health Services, the World Health Organization (WHO) has played a seminal role in guiding and developing school health (St. Leger, 1999). It has to its credit the publication of a number of reports about child health and the related role of schools, as well as the formation of a number of international school health initiatives. At the same time as the WHO was building the momentum for school health promotion, with a great deal of work taking place in Europe, the 1979 U.S. Surgeon General's Report on Health Promotion and Disease Prevention focused on children and youth and the value of comprehensive health programs at school. This report provided the impetus in the United States for the way school health developed.

The concept of Comprehensive School Health (CSH) has emerged as a worldwide strategy in the past fifteen years as a way to address the health status of children and youth. CSH is a multifaceted approach to health promotion. For example, it comprises a number of different components such as health curriculum and instruction; supportive environments; and community engagement and addresses health related topics, often referred to as risk factors, such as physical activity, healthy eating, mental health, tobacco and substance use.

In Canada, the Comprehensive School Health (CSH) approach is based on both the European and U.S. models. The Public Health Agency of Canada (PHAC) defines Comprehensive School Health as "an integrated approach to health promotion that gives students numerous opportunities to observe and learn positive health attitudes and

behaviours. It aims to reinforce health consistently on many levels and in many ways” (PHAC, 2004, ¶1). Comprehensive School Health is based on a partnership between students, teachers, parents, health professionals and the community in order to acknowledge and address the determinants of health that impact the well-being of students. “The Comprehensive School Health approach promotes health within and beyond the classroom, encouraging values, skills and actions that foster the healthy development of students” (PHAC, 2004, ¶1).

Different organizations and countries present slightly different models; there are variations even within the Canadian context. For the purposes of this thesis, I have adopted the goals and components as outlined in the *CSH Consensus Statement*, prepared by the Canadian Association for School Health (CASH, 2006) and endorsed by a number of Non-Government Organizations (NGOs) as well as the Public Health Agency of Canada. The Consensus Statement, which reflects the focus on both individual health behaviours and supportive environments, is comprised of four elements of a CSH approach which are Teaching and Learning (Instruction), Health and Other Support Services (Preventive Health Services), Supportive Social Environments (Social Support) and Healthy Physical Environment. Further, the authors of the Statement acknowledge the Determinants of Health as influencing the health of children and youth and reinforce that in general CSH “refers to a multifaceted approach that includes teaching health knowledge and skills in the classroom, creating health-enabling social and physical environments and facilitating links with parents, local agencies and the wider community to support optimal health and learning” (CASH, 2006, p. 4).

### *The Need for this Research*

As Comprehensive School Health has continued to garner interest as a health promotion strategy, there have emerged a number of organizations dedicated to its implementation and evaluation. For example, the virtual, Canadian-based, School Health Research Network is comprised of researchers, policy-makers, and practitioners interested in school health promotion from around the world. Network members asserted a need to investigate the impact, role and effectiveness of the CSH approach because health and learning are connected, school health programs can save money, multiple coordinated interventions are more effective and ecological understanding of social and physical environments leads to insights (School Health Research Network, n.d.). A list of over 75 topics related to school health was generated by Network members through interviews with key informants, an email survey of about 100 school boards and public health officials, and a workshop with researchers, government staff and NGOs. One of the issues raised (referred to as a topic) indicated that although there are several examples of schools adopting a Comprehensive School Health approach, they had not been studied. Questions of interest included: How did the schools get started? How does the school implement CSH? How did they fail? How can a CSH approach be sustained?

### *Purpose of the Research and Research Questions*

According to Stewart-Brown (2006), many studies do not address key components of a Health Promoting School approach such as school culture or participation in developing programs. In fact, she found that while using components of the approach contributed to effectiveness (e.g., sustained, multifactorial, whole school

approaches), no studies had addressed initiatives that had adopted the health promoting schools approach in its entirety. Still to be determined then are questions such as: how did a specific health promoting school initiative work? Why did it succeed in this context? What might make this initiative more effective?

With the hope of contributing to the overall body of qualitative research in the area of Comprehensive School Health, combined with my personal desire to tell the story of one specific school's health promotion efforts, I selected this topic as the focus for this thesis. The purpose of this ethnographic case study was to describe the characteristics of one school's Comprehensive School Health initiative and to explore the experiences of school community members in order to gain an understanding of how one school embraced a Comprehensive School Health approach. The guiding research questions included:

- How do participants define Comprehensive School Health?
- What was the impetus to engage in Comprehensive School Health?
- How is Comprehensive School Health practiced?
- What are the challenges in implementing Comprehensive School Health?
- How do participants define the success related to Comprehensive School Health?
- What do participants identify as the key ingredients of a Health Promoting School?

This thesis consists of seven chapters. Chapter 2 provides a review of the relevant literature with a focus on the concepts of health and health promotion, the history of Comprehensive School Health, Comprehensive School Health from a socio-ecological perspective, and Comprehensive School Health as a health promotion strategy. Given my unique role at the school in light of the research undertaken, Chapter 3 defines my role as

an 'insider', and serves to situate me both prior to and during data collection. It has been placed before Chapter 4, which describes the research process, in order to provide the complete context before describing how the research was undertaken. Chapter 5 presents and discusses the findings from the research, followed by Chapters 6 and 7 addressing reflexivity and conclusions and recommendations respectively.

## CHAPTER 2

### LITERATURE REVIEW

This chapter provides an introduction to the literature pertaining to various aspects related to Comprehensive School Health. First, this chapter highlights health and health promotion as fundamental concepts, followed by health issues of children and youth. Finally, Comprehensive School Health is reviewed from a socio-ecological perspective and in terms of its effectiveness as an overall health promotion strategy.

#### *The Concepts of Health and Health Promotion*

Health is the capacity or resource for everyday living that enables us to pursue our goals, acquire skills and education, grow and satisfy personal aspirations (Public Health Agency of Canada (PHAC, 2002)). While health in Canada has been primarily discussed within the context of our universal health care system, political concerns about rising health care costs in the 1970s provided the impetus toward an alternative view. In 1974, Marc Lalonde, Liberal Minister of Health and Welfare Canada, author of a report titled *A New Perspective on the Health of Canadians* (Lalonde, 1974) acknowledged that medicine and the health care system play only a small role in determining one's health. Lalonde suggested that improving health in the future would be a result of changing individual lifestyles and improving the quality of the environment, with human biology and health services also playing a role. The report, also known as *The Lalonde Report*, was the first government report to introduce the concept of "health promotion".



The release of this report sparked activity in an emerging health promotion field. For example, a federal Health Promotion Directorate was established in 1978 within the Department of National Health and Welfare (now Health Canada). It merged a number of different units including those working in the areas of alcohol, tobacco, and nutrition to name a few. The Directorate was responsible for policy and program development, knowledge development and funding programs to support community action. They were also involved in supporting social marketing campaigns to encourage a number of positive lifestyle choices including physical activity through financial support to ParticipACTION (Bell & Joly, 1997; J. Hauser, personal communication, January 14, 2009).

Second, a series of political events (e.g., advent of the Health Promotion Directorate, Beyond Health Care Conference, Canada Health Act, First National Health Promotion Survey) established health promotion as a credible and necessary strategy and eventually led to Canada hosting the first International Conference on Health Promotion in 1986 (Bell & Joly, 1997; J. Hauser, personal communication, January 14, 2009). It was at this conference that The *Ottawa Charter for Health Promotion* (WHO, 1986) (See Appendix A) was conceived, and reflected the philosophy that social and environmental factors, perhaps more so than individual lifestyle behaviours, influenced health. The Ottawa Charter for Health Promotion (“The Charter”), described as a “charter for action to achieve Health for All by the year 2000 and beyond” (WHO, 1986, p. 1), consists of three main areas. First, it outlines the *prerequisites for health* – conditions and resources that serve as the foundation for health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, and social justice and equity. Second, it features three

roles of health promoters. They must: (1) advocate for conditions that support health; (2) enable people to be as healthy as possible by ensuring they have the means to do so; and (3) mediate between all the sectors in society – both with and without a health mandate – to ensure that health is considered and reflected in their work. Finally, the Charter describes a five-strategy framework that defines health promotion which are Build Healthy Public Policy, Create Supportive Environments, Strengthen Community Actions, Develop Personal Skills, and Reorient Health Services.

Since the creation of *A New Perspective on the Health of Canadians* and the *Ottawa Charter*, much work has taken place in Canada and internationally (c.f. *Strategies for Population Health: Investing in the Health of Canadians*, 1994; *First Report on the Health of Canadians*, 1996; *Toward a Healthy Future: Second Report on the Health of Canadians*, 1999) that builds on health promotion and moves toward a population health approach.

A population health approach addresses the entire range of individual and collective factors that determine health. Population health strategies are designed to affect whole groups or populations of people. The overarching goals of a population health approach are to maintain and improve the health status of the entire population and to reduce inequities in health status between population groups. (Health Canada, 2001, p. 2)

In light of this shift, health promotion efforts have identified the key determinants of health, building on the Ottawa Charter's pre-requisites of health mentioned above. These complex and interrelated determinants, often outside the realm of responsibility of the health and the health care sector, include: income and social status, social support

networks, education, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetics, health services, gender and culture (PHAC, 2002). While the determinants are interrelated, each is also significant on its own. In particular, a focus on children's health and healthy development has become an area of increasing concern in the health field. It is this demographic group that is the focus of this research. In the following sections the health issues of children and youth are reviewed as well as Comprehensive School Health.

### *Health Issues of Children and Youth*

It is important to conceptualize children's health as an issue, particularly in light of the determinants of health and the direction of The Ottawa Charter. Both the social-ecological model and the related strategy of Comprehensive School Health address the broader influences on the health of children, however, it is outside of the scope of this research to address all the factors and influences in great detail. Therefore, this section will provide a brief overview related to health issues of children and youth.

According to Rogers (1997), "age is a determinant of vulnerability" (p. 66), therefore children are considered to be vulnerable. They are completely reliant on others for care and may not be in a position to advocate for their own needs. Adolescents are also vulnerable, not for the same reasons as children, but rather because they tend to participate in more risk-taking behaviours, such as experimentation with alcohol and drugs, and are more prone to accidents (Rogers, 1997). The term "vulnerability" tends to describe individuals in society who are susceptible to health problems, harm or neglect

and is based on reality and perception, as well as circumstances. Rogers (1997) described vulnerable individuals as those who carried a higher risk of poor physical, psychological and/or social health. Other determinants of vulnerability include gender, race and ethnicity, education, social support, income, the interaction of the individual and the environment, and modifiable and non-modifiable risk factors. Given the age of the participants in this study, the factors described above that impact on children and the relationship between the individual and their environment, Comprehensive School Health may be a particularly relevant approach to take to impact the health of children.

The Canadian Council of Social Development (CCSD) released a report in 2006 titled *The Progress of Canada's Children and Youth*. In this seventh annual report tracking the well-being of Canadian children and youth, based on a number of Canadian surveillance and monitoring tools, a number of issues affecting a child's health were highlighted. First, despite a federal goal of eliminating child poverty by the year 2000, more than 1.2 million Canadian children, or one child in every six, lived in poverty in 2003. Certain groups of children were more likely than others to live in poverty including Aboriginals, recent immigrants, visible minority children and children with a physical disability. In 2000, 1.2% of children aged 2 to 11 experienced hunger due to poverty. In 2004, over half of food bank users (55%) were families with children. In 2004, food banks served 317,242 children and youth. Second, in 2001, 15% or 782,400 children lived in inadequate housing, defined as housing that required major repairs, was unsuitable in terms of size and make-up for the family and cost more than 30% of the family's before-tax income. Adequate housing was linked to healthy child development including a child's success at school and community connectedness. Third, 16% of

children under 18 were exposed regularly to second-hand smoke in their home. Fourth, children were more vulnerable to the effects of outdoor air quality such as smog, pesticide use, and water quality. Finally, access to recreational opportunities, irrespective of the type of activity, was a barrier to children in low-income families. In addition, children with disabilities were less likely to participate in social or recreational activities with the likelihood of exclusion rising with the severity of the disability. Reasons included lack of facilities or lack of accessible facilities, unavailable transit, expense, and no attendant available to assist the child.

While the statistics above emphasized some of the issues as being related to low-income, the Health Council of Canada, in their 2006 report *Their Future is Now: Healthy Choices for Canada's Children & Youth*, pointed out that “While children in the lowest-income families are more likely to experience problems with health and development, a high proportion of children in middle income and higher-income families also have problems” (p.3). Further, according to that report, Canada’s youth were felt to be fairly healthy at the time of the report, but the authors suggested that a growing number of issues were causing concern and needed to be addressed. Failure to address the issues would affect both the current quality of life of our children and youth as well as having an impact on the country’s social and economic well-being in the future, including the cost and complexity of treating health issues rather than preventing them in the first place. Some of the issues reported by the Health Council of Canada and deemed priorities included the following:

- Despite free immunization programs, many two-year-olds do not have all their vaccinations.

- Three of every 100 children in Canada are living with a disability or chronic illness. Children and youth with disabilities are not able to participate as fully as other children in school, recreation or the workforce.
- Unintentional injuries are still the leading cause of death and a major cause of hospitalization among children and youth.
- An estimated 1.1 million – or 14 per cent – of Canada’s children under age 20 have mental health conditions that affect their lives at home, at school and in the community.
- Over one million Canadian children are overweight and another 500,000 are obese. Unhealthy eating and lack of physical activity are contributing to the problem.

*(Health Council of Canada, 2006, pp. 17-20)*

What these reports highlight is the urgency for dealing with child and youth health and the complexity of this issue. One initiative, introduced earlier, that has targeted the health of children and youth is CSH, which is discussed below.

### *The Development of Comprehensive School Health*

St Leger (1999) has outlined the chronological events that led to the development of the health promoting school concept, beginning with the work of the World Health Organization (WHO) that played a seminal role in guiding and developing school health. In 1950, an Expert Committee on School Health Services, established by the WHO, produced a report calling for, among other things, a more comprehensive approach to curriculum programs in health and pre-service training for teachers in the area of health. A second report in 1954 provided a significant change in thinking by suggesting that the

school and non-school sectors in health education should both train together and work together. In the 1960s the WHO worked closely with the United Nations Education, Scientific and Cultural Organization (UNESCO) to develop one of the first international documents to serve as a guideline for schools to plan and implement school health initiatives.

Throughout the 1960s and 1970s, the WHO produced a number of general reports about child health in which they continued to emphasize the important role of schools. They promoted the concepts of establishing relationships between health and education; considering community needs and problems; linking more closely with the community by developing closer relationships between children, teachers, parents and community members; cooperation between community organizations including research activities; health education training for teachers; and the involvement of children in community health projects. Two other important WHO sponsored events played a significant role in furthering the concept of school health. The key event, often referred to as the foundation of the health promoting schools concept, was the development of *The Ottawa Charter for Health Promotion* (WHO, 1986). The Charter served to support and emphasize the use of settings as an approach to health promotion, particularly through one of the five strategies in the framework called *developing personal skills*. It also reflected the philosophy that social and environmental factors, perhaps more so than individual lifestyle behaviours, influenced health.

In the United States, as a result of the 1979 U.S. Surgeon General's Report on Health Promotion and Disease Prevention that focused on children and youth and the value of comprehensive health programs at school, much work was done that shaped the

practice of school health initiatives. In the 1980s school health was shaped by three major areas – classroom health instruction, school health services and a healthy school environment. In 1987, Allensworth and Kolbe expanded the model to eight components, a model which is primarily used today throughout the United States and in some parts of Canada. It comprised Health Education, Physical Education, Health Services, Nutrition Services, Counseling, Psychological, and Social Services, Healthy School Environment, Health Promotion for Staff, and Family and Community Involvement.

In 1991, the WHO and the International Union for Health Education identified schools as a key setting for health education efforts. In addition, 1991 was also the year that the European Network for Health Promoting Schools (ENHPS) was established with three pilot countries - Poland, Hungary and Czechoslovakia. As of April, 2006, 43 European countries belonged to the ENHPS (ENHPS, 2006)<sup>1</sup>.

WHO built on the success of the ENHPS by launching a *Global School Health Initiative* in 1995 (Ronson & MacDougall, 2003). The initiative was based on six guidelines that encouraged schools to go beyond teaching health knowledge and skill development. The six guidelines were school health policies, the physical environment of the school, the social environment of the school, school/community relationships, the development of personal health skills and school health services (WHO, 1995, St Leger, 1999, Stewart-Brown, 2006). Additional guidelines outlined issues that were critical to the effectiveness of a health promoting school including the development of good relationships within the school; the promotion of staff health and well-being; promotion of self-esteem among pupils; consideration of staff exemplars in health-related issues (Stewart-Brown, 2006). That year, 27 countries in the Western Pacific region of the

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<sup>1</sup> During the writing of this thesis, the network name was changed to Schools for Health in Europe (SHE).



WHO were invited to join the health promoting schools initiative. Australia and New Zealand joined the movement in 1997 and are among the most fervent supporters of the strategy. Regional Networks for the Development of Health-Promoting Schools have also started in Latin America and South Africa, with others still in the process of developing (Ronson & MacDougall, 2003).

Different organizations and countries present slightly different models; there are variations even within the Canadian context. While the term Health Promoting Schools is used in Europe and Australia and in the United States this approach is referred to as a Coordinated School Health Program, school health advocates in Canada primarily use the term *Comprehensive School Health*. Since the term Health Promoting School is also frequently used, the terms Health Promoting School and Comprehensive School Health are used here interchangeably. For the purposes of this thesis, the goals and components as outlined in the *CSH Consensus Statement*, prepared by the Canadian Association for School Health (CASH, 2006) were adopted (See Appendix B).

#### *Comprehensive School Health from a Settings-based and Socio-ecological Perspective*

It has been broadly asserted in reports such as The Ottawa Charter (WHO, 1986) and the Jakarta Declaration (WHO, 1997) that in order to shift the focus away from the view of health as merely the absence of disease to the notion of health as a resource for daily living, health promoters must examine how they promote health. The term “health promotion” has broad connotations but within the health field it has often been interpreted as, and translated into, interventions that reflect a philosophy of healthy lifestyles being solely a personal responsibility with little consideration for the factors

that impact on the individual, such as the environment in which they live, learn, work and/or play. There has been a significant shift in focus to a broader health promotion perspective that targets not only the individual, but also takes into account the context of the individual.

The Ottawa Charter (WHO, 1986) served to support and emphasize the use of *settings* as an approach to health promotion as exemplified through the statement: “health is created and lived by people within the settings of their everyday life; where they learn, work, play and love” (WHO, 1986, p.3). In 1991, the International Union for Health Education identified schools as a key setting for health education efforts. The Jakarta Declaration on *Leading Health Promotion* (WHO, 1997) further emphasizes the importance of settings. The Declaration states the importance of health, not only to the well-being of the individual, but also to the social and economic potential of having a healthier society.

The WHO Glossary (WHO, 1998) defined settings for health as “a place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being” (p. 19). The definition also included a more concrete picture of a setting as having physical boundaries, people with defined roles and an organizational structure. Dooris (2004) questioned whether or not settings should be confined to “organizations” for if that were the case, where would cities, communities and neighbourhoods fit? Further, different settings have different organizational structures. Hospitals and schools operate much differently and have different needs than a home or community. Even between settings, there are differences, such as the needs of a primary school versus an institution of higher learning. The

question remains: how can we take an effective or evidence-based settings approach from one organization and successfully implement it in another?

Dooris (2004) argued that a settings-based approach supported health beyond the absence of illness by investing in the social systems where people live. This further supported the WHO's Jakarta Declaration (1997) of health for socio-economic benefits. Dooris (2004) also recognized that health issues do not respect the boundaries of settings given that people lived their lives in many settings. This argument would support the concept of a health promoting school that not only encompasses the school, but also extends to the home, the community and in some cases, workplaces in the community that may interact with the school.

Many benefits and challenges of a settings-based approach have been determined through empirical research. According to Whitelaw, et al. (2001) some of the positive outcomes included: an increased awareness of health issues; the development of health promoting policies; the creation of budgets specifically for health promotion activities; improvements in "structural" and "psychosocial" environments; more frequent and better partnerships; the development of discrete health promotion / education projects; changes in various individual attributes, behaviours and functioning; and economic benefits. A settings-based approach was thought to be an ideal way to bring together the individual focus of health promotion with the population health approach, two strategies which quite often were placed at opposite ends of a continuum of practice. According to Dooris (2004), because people are neither defined by their risk factors, nor isolated from the world around them, a settings approach considers all those factors. Settings were an efficient way to reach people given that the time they spent together in a particular setting

leant itself to frequent interaction. The formal and informal ways that people interacted within a setting may have also offered the benefit of social influence. Finally, a settings-based approach provides an opportunity to deploy initiatives using all five strategies of The Ottawa Charter: *developing personal skills; strengthening community action; creating supportive environments; building healthy public policy; and reorienting health services.*

Whitelaw, et al. (2001) cautioned that “those who do deploy a settings model need to ensure that their work is more than simply a superficial re-packaging of traditional individualistic health education in a particular setting” (pg. 348). One further challenge they found was that health promotion efforts that focused on a setting were challenged with the concept of sustainability, a key concept for health promotion efforts irrespective of approach. Further, they claimed that the settings field must be more critically examined. Those interested in a settings-based approach must work more collaboratively with partners across settings. Health promoters must consider the fact that many people, particularly those who are most in need (e.g., the unemployed, homeless, small business employees, children not at school) are not found in traditional settings.

Much of the ongoing debate around the notion of schools as health promoting settings is the question of whether schools should be focusing exclusively on education given the demands of the curriculum or whether they should have a role in promoting health. According to Miller (2003), one of the key factors underpinning the settings approach is the socio-ecological perspective of health behaviour and health promotion. “An ecological approach recognizes that individuals live in social, political, and

economic systems that shape behaviours and access to the resources they need to maintain good health” (p. 14). Ecological models consider the influences on individuals such as environment, behaviour and policy, all of which impact an individual’s ability to make healthy choices. Freudenberg, et al. (1995) stated that ecological models illustrate the connections among individual, peer, community and social factors. They claimed that ecological models consider the other factors that may impact the individual’s ability to engage in a healthy lifestyle that most mainstream social psychological theories deemphasize.

Minkler (1999) questions whether an individual’s health behaviours are his/her responsibility alone, or whether or not society (e.g., influencers, organizations, public policy) should take some responsibility. She argues both for and against personal responsibility, with the resolution being the case for a balanced ecological approach.

According to Syme (as cited in Minkler, 1999):

No one would [question] that, as individuals, we are responsible for our health. In the final analysis, we are the only ones who can change our behavior. We are the only ones who lift fork to mouth, who inhale smoke, who plant feet on sidewalk. And we are the only ones who can *decide* to do these things ... [But] we don’t live in a vacuum. Whether we like it or not, our thoughts, ideas, wishes and behaviors are influenced and conditioned by the people around us, by the environments in which we find ourselves, and by the customs, traditions, fads and fashions to which we are continuously exposed.... Effective behavior change therefore requires that we do our best as individuals, but also that we work together

with one another to create more healthful and supportive social environments. (p. 131)

Minkler (1999) emphasizes two concepts of the ecological perspective.

First, there is the notion that individual behaviour is the ultimate goal yet the determinants of health are clearly considered. Second, intrapersonal change, while paramount, is not targeted to the exclusion of interpersonal, organizational, community and policy levels. In fact individual change can also influence change in the other areas that influence an individual; that is, there is a “reciprocal relationship between people and their environments” (p. 131). Moreover, Sallis, Bauman, and Pratt (1998) argued that while environmental and policy factors can better explain influences on behaviour than just intra- and inter-personal factors, no socio-ecological theory would denounce the other variables on behaviour.

McLeroy, Bibeau, Steckler, and Glanz (1988) developed a socio-ecological model comprised of five different layers of interventions and the interactions between them. The first layer is “Intrapersonal Factors”, where interventions would aim to increase knowledge, change attitudes and help to develop personal skills. Second, “Interpersonal Processes and Primary Groups” refers to formal and informal social networks and support systems and includes the influencers to a targeted population in an intervention, such as social groups, family, friends, or co-workers. The third layer is “Institution” which describes a social setting with formal or informal rules and regulations including companies, schools, and hospitals. The fourth layer, “Community”, describes relationships between organizations and institutions as well as internal relationship based on boundaries assigned to “community”. The fifth and final layer, “Public Policy”, is a

policy or law at the municipal, provincial, federal and/or international level. The premise of this model, then, is that behaviour change in both individuals and populations will be affected by targeting interventions within and between each of these layers.

Brownson, Koffman, Novotny, Hughes, & Eriksen (1995) showed effective use of an ecological-based intervention in the area of smoking cessation while Giles-Corti & Donovan (2002) focused on physical activity in a large urban area with more than 1,800 adults. Minkler (1999) describes the success that Canada has had related to its efforts to reduce tobacco use nationally. Health Promotion interventions have addressed all levels of the socio-ecological model such as the policies that have been put in place to change marketing practices, crop substitution and smoking in the workplace; funding has been given to social marketing campaigns to urge people to quit smoking and local health departments offer health promotion strategies including smoking cessation programs; and the efforts to eliminate tobacco sponsorship.

While there is support for the socio-ecological model, a number of reports recommend caution and further study. Freudenberg, et al. (1995) argued that most ecological models are too complex, making empirical testing difficult. Further, this model, like some others, is difficult for the health promoter to put into practice, keeping the focus on creating change within such a broad context. Sallis, et al. (1998) pointed out that while it can be difficult for health promoters to focus on all of the different levels, it is imperative that when developing interventions, to distinguish between the interventions directed at settings versus targets. They also argued that this model, while the most applicable from a physical activity perspective, lacked a specific category for “physical environment factors”. This was deemed relevant, given their recommendation that

environmental interventions should be implemented prior to educational interventions in order to ensure that supports are in place in order to carry out a suggested activity (e.g., suggesting a mall walking routine when no malls are open for that type of activity).

Minkler (1999) cautioned that socio-ecological approaches may put too much emphasis on social responsibility and that it is important to consider how an individual's life circumstances impact on how they interact within their environment. From an implementation perspective, Minkler (1999) also pointed out that within the Canadian context, despite being a world leader in this area, many funded health promotion projects focused their activities on the interpersonal and organizational levels, community and political levels were most often neglected, concluding that "it remains relatively rare to encounter multi-target, multi-setting programs that fully integrate an ecological approach toward health promotion interventions" (Minkler, 1999, p. 134). She added that for programs that use an ecological model, evidence of effectiveness in terms of declines in morbidity and mortality were not available which may indicate the difficulty in both implementing and evaluating a strategy based on an ecological framework.

Miller (2003) stated that when considering a health promoting schools model, it is important to be cognizant of the many aspects of health to be considered, and in turn, the health promotion capacity of a school.

The best practices of ecological models within the school environment provide clear direction for future research implementing two principles of the Ottawa Charter, namely, encouraging community action and linkages between schools and other agencies, and reorienting health services to



enhance youth access and identifying services best carried out in schools.

(p. 29)

This section presented a sample of literature related to a settings based approach and a socio-ecologic framework as the basis of a Comprehensive School Health approach. The next section will describe some of the evidence related specifically to the Comprehensive School Health approach.

### *Comprehensive School Health as a Health Promotion Strategy*

“The school is potentially one of the most important and effective agencies for promoting health, including mental health” (Weare & Markham, 2005, p. 14). According to Leurs, et al. (2006), a limited, yet growing, number of studies world-wide have shown that school health promotion efforts are a positive and cost effective way to improve students’ health so that they have the potential to benefit from school. Further, they point to studies that support integrated, long-term approaches as being more effective than short-term prevention programs targeted solely at classroom-based curriculum.

Rudd and Chapman Walsh (1993) state that schools are in the business of education, not health protection and promotion. Further, they argue that the health message is secondary and in some cases may even compete with the primary mandate of the schools as a social and educational agency. While St Leger (2001) agreed and pointed out the school’s knowledge of health is limited, he also cites research that indicates a strong link between poor health and educational achievement. As a result, the educational sector is beginning to understand and accept that a “whole school” approach to health and social issues will ultimately help to fulfill their primary mandate of education.

A Comprehensive School Health approach, St. Leger (2001) argues ... is not a vehicle for legitimising topic-based and school-located health promotion interventions in areas such as drug reduction, weight management and injury prevention. When mapped in educational terms, it demonstrates that its prime purpose is achieving education goals through addressing health issues within an education framework. (p. 198)

St Leger and Nutbeam (2000) proposed that adopting a health promoting school approach could result in four main school-related outcomes which would ultimately provide the foundation upon which to meet both education and health objectives and that are paramount to health literacy. The four outcomes are lifelong learning skills; competencies and behaviours; specific cognate knowledge and skills; and self attributes.

In examining the literature, it is worth noting some of St Leger's (1999) cautions. First, he noted that there are many studies of health promoting schools that outline potential benefits, *if* schools employed a comprehensive framework. He also added that much of the literature may credit the effects of an intervention to Comprehensive School Health, when in fact it really describes topic-based interventions that only employed one or two of the principles of health promoting schools. For proponents of the theory that health promoting schools should contribute to healthier students, the thought is that it is critical to link the curriculum with the school environment and community, that is, to address health issues much more broadly than through classroom curriculum.

Moon, et al. (1999) examined a number of studies and argued that while health education and the accompanying evaluation of its effectiveness has grown in recent years, there is little evidence to suggest that education or knowledge-based approaches

alone lead to medium- or long-term change, and that knowledge alone is not enough to enable people to make healthy choices and ultimately change behaviours. He noted, however that the research supports the foundational steps upon which CSH is based: parent and family involvement; the participation of the wider community; “the importance of a comprehensive, coordinated, cross-curricular programme throughout the school career” (pg. 112); joint health education and promotion initiatives; various teaching methods and strategies; the involvement of students in the decision making process. Moon et al. (1999) posited that,

They [WHO] have recognized that the link between a child’s health and education is a powerful one, and state that ‘school health programmes that coordinate the delivery of education and health services and promote a healthy environment could become one of the most efficient means available for almost every nation in the world to improve significantly the well-being of its people. Consequently, such programmes could become a critical means of improving the condition of humankind globally’. (p. 112)

St Leger (2001) cited a number of studies from 1994 – 1999 that supported the Health Promoting School approach as being a promising practice by offering a logical, comprehensive and strategic approach to school health, but that the evidence was inconclusive in terms of CSH being the gold standard of all school health promotion strategies. St Leger (2001) reported that learnings from research showed that programs need to strive toward cognitive outcomes, social outcomes, and behaviour change within an educational framework; be developmentally appropriate; take place over several years;

receive adequate funding; provide professional development for teachers; be based on learning theories; work within the limitations of the school and recognize opportunities.

More recently, Mukoma and Flisher (2004) and Stewart-Brown (2006) reviewed health promoting schools and school-based health promotion initiatives respectively. In their examination of nine health promoting schools, Mukoma and Flisher (2004) found positive developments in terms of policy development, organizational structures put in place to facilitate health promotion activities, integration of health promotion into school curriculum and parent and community involvement in planning and implementation of initiatives. Policy development is of particular interest because St Leger in his review of evidence (1999) found “little evidence which supports the policy component of the health promoting school” (p. 56), from the point of view that although policies were instituted, few studies evaluated their impact. Interestingly, St Leger (1999) stated that little evidence had been provided to support policy as a way of improving health.

Stewart-Brown’s (2006) research on school-based health promotion initiatives addressed mental health, substance use prevention, healthy eating, physical activity, and health promoting schools. In terms of the evidence supporting school health promotion in improving health, the synthesis found that programs can be effective, depending specifically on the health issue being addressed. The programs found to be most effective were those addressing mental health (including violence prevention, aggression and conflict resolution), healthy eating and physical activity. Programs that aimed to prevent substance abuse and improve self esteem were among the least effective. Programs addressing physical activity and healthy eating were considered to be more sophisticated and the most likely to address school environment and parent involvement. Programs

addressing violence were most successful when implemented within a health promoting schools approach, including whole school involvement, physical and supportive environmental changes, personal skill development, involvement of parents and the wider community, and long-term implementation.

With respect to the effectiveness of a Health Promoting Schools approach, Stewart-Brown (2006) determined that the programs most effective in changing health or health-related behaviours shared some common characteristics including being complex, long-term, multifactorial and addressed numerous elements such as curriculum, school environment and community, characteristics consistent with the health promoting schools approach (WHO, 1996). Overall, however, findings were mixed in terms of the effectiveness of the Health Promoting Schools approach. It should be noted that none of the schools used the Health Promoting Schools approach in its entirety.

Consistent with the themes from Stewart-Brown (2006), are the results from the Coordinated Approach To Child Health (CATCH) program in the United States. CATCH is a multi-component, multi-year coordinated school health promotion program. It targets children in grades three to five and primarily addresses healthy eating, physical activity and tobacco use. It was the first ethnically diverse research trial to integrate school, child and family. CATCH was the largest school-based health promotion study ever funded with the controlled clinical trial taking place in 96 schools in four states with 5,100 students. The results from the study found that CATCH schools were successful in reducing total fat and saturated fat content of school lunches, increasing moderate-to-vigorous physical activity during physical education classes and improved students' self-reported eating and physical activity behaviours (Nader, Stone, Lytle, Perry, Osganian,

Kelder, et al. 1999). Three years later, without any intervention, results showed continued healthy behaviours in the form of lower fat intakes and higher levels of physical activity (Hoelscher, 2004).

While research has reported many advances in the adoption of health promotion by schools, research has also found a number of limitations. Deschesnes, Martin and Hill (2003) presented studies by Lynagh, Schofield and Sanson-Fisher (1997) and Marshall, Sheehan, Northfield, Maher, Carlisle and St Leger (2000) who analyzed 113 school programs, none of which covered all of the different areas that make up a Comprehensive School Health approach. In fact the majority of programs focused on health related curriculum only. Studies in the United States also failed to demonstrate coordination and integration between elements. Research conducted by the Centers for Disease Control and Prevention (as cited in Deschesnes et al., 2003) found few programs that linked with the parent and external community and also had difficulty determining to what extent the components common to a coordinated school health approach were introduced concurrently and in a coordinated fashion in each of the schools. Stewart-Brown (2006) identified the same gap in the evidence – she found that no studies had analyzed initiatives that used all components of a health promoting school model. The WHO Experts Committee (1997) has stated that developing a CHS approach directed at individual domains can be easily accomplished but operationalizing the inter-relationships between the domains is much more difficult. This was supported by the fact that most of the programs focused on the development of personal skills but did not focus on school environment or community participation. Deschesnes et al. (2003) hypothesized two potential reasons for these findings. First, the Health Promoting School

model may be too complex and difficult to implement. Second, since the concept is still fairly new, there are few evaluative results available upon which to base a decision about its utility. The authors believed that the issue of complexity was the most relevant as it raises questions of overall feasibility and what conditions need to be present in order to put a Comprehensive School Health approach into practice.

This issue was examined by Rudd and Chapman Walsh (1993) who identified a number of barriers to a Comprehensive School Health approach when they were making the case for the concept as a workplace initiative for teachers and staff. They stated:

... there are some nettlesome problems that include administrative and bureaucratic lethargy, entrenched standard operation procedures, and intersectoral or interdepartmental rivalries as well as serious fiscal constraints that often stand in the way of innovation and change.

Furthermore, both school sites and worksites must live in a dynamic equilibrium – a kind of creative tension – with a surrounding community.

They depend on that community for inputs like material and human resources as well as for social legitimacy and they ignore or disturb that equilibrium at their peril. When organizational or community norms and professional standards come into conflict, arguments are not logically resolvable because proponents start from different premises. (p. 503)

Rudd and Chapman Walsh (1993) suggested a number of ways that the education and health promotion sectors must work together effectively, including the need to find common ground in terms of health-related goals of children and the institutional mandate of schools as well as the needs of students, teachers, the institution and the community.

Miller (2003) highlighted a concern about the capacity of schools to implement and sustain health promotion programs as many of the studies he reviewed identified educator training and participation as the problem. He argued, however, that educators have supported great numbers of health promotion programs over the years, until funding cuts and / or political change put an end to them and arrested the community development process that can take many years to build. Furthermore, schools, he stated, have invested time and resources into health promotion programs but when human and financial resources are withdrawn, school budgets cannot support the creation and sustainability required with community partnerships.

Studies about school health promotion and the concept of Comprehensive School Health often seem to report various findings about effectiveness, although many positive changes have been reported. Stewart-Brown (2006) elucidated some of the draw backs in the way that research is currently conducted in the area of CSH and adds that there is much debate about research methodology in this field. She points out that much of the research is based on Randomized Control Trials (RCTs) with quantitative outcomes. According to Stewart-Brown (2006), one policy-making group at WHO has deemed RCTs “inappropriate, misleading and unnecessarily expensive” (p. 14). She argues that in order to determine effectiveness, implementation is paramount to the success of health promotion initiatives, therefore process evaluations are key. Few of the studies she looked at reported information about how the program was implemented. “Their results therefore represent the so-called black box approach to health promotion, aiming to identify whether an intervention worked without asking questions about what was actually involved in the intervention” (Stewart-Brown, 2006, p. 15). She also argues that



RCTs are inappropriate given that CSH initiative require some degree of individual tailoring by the school, therefore standardizing an approach is next to impossible and school culture, key to a health promoting school, may take years to develop. Overall, she argues for a variety of methodological approaches including process- and out-come based evaluation, and quantitative and qualitative methods.

Thus, evidence seems to support some features of a Comprehensive School Health approach. However, not enough is known about how the approach works in its entirety to declare whether or not it is more effective than traditional health promotion approaches in schools. Given the complexity of the Comprehensive School Health approach, more research is needed to explore its development and implementation.

## CHAPTER 3

### INSIDER ROLE

This chapter provides insight regarding my role as an insider at the research site. I have chosen the subject of Comprehensive School Health because I am passionate about it – from both a personal and professional point of view. Physical activity has always been an important part of my life. Perhaps it was that interest in and commitment to physical activity and health that led me to my first career as a Registered Nurse. Working in Orthopaedic surgery, it struck me that there were so many people for whom I cared whose illnesses and conditions were related to an unhealthy lifestyle, particularly to a lack of physical activity and / or unhealthy eating. Furthermore, they often lacked the information and personal skills required to make healthy choices and had little to no social support required to sustain the necessary changes. It was not only frustrating to witness the preventable chronic diseases, but it was even more frustrating to work in health care with very little time to provide education to patients and their families or friends with a specific focus on health promotion and disease prevention.

This combination of personal interest and commitment to physical activity and a growing restlessness and discontent with the shortcomings of the health care system eventually pushed me to leave nursing to pursue a career in a related sector. While my initial goal upon returning to university to complete my degree in Physical Education was to work in the area of amateur sport, I soon realized my heart remained in health, but with a focus on health promotion.

As part of a certificate program in conjunction with my degree, I participated in a field work experience at the (then) Ministry of Tourism and Recreation where I

coordinated a provincial initiative known as Sneaker Day. Not only was the experience invaluable as a first taste to physical activity promotion, but it helped lead me to ParticipACTION, a well-known and successful national physical activity social marketing organization. I worked for ten years at ParticipACTION in a variety of roles with the last one being Director of Health Education. ParticipACTION closed in January 2001 at which time I was afforded an opportunity to work in public health, a community-based organization with a focus on health promotion. As a Physical Activity Specialist, with a mandate to serve community members of all ages, I was eventually moved to the child and youth team, a role that became more and more centred around schools as a setting to reach children. It was apparent, however, that given the complexity of child health, family and community support was essential. It was during my time in public health that I decided to pursue a Master's degree.

The most important event to decisively strengthen my interest in Comprehensive School Health has been my first hand experience with the school system as a parent. In 1997, the first of my two daughters was born, followed by the second at the beginning of 1999. My daughters began Junior Kindergarten at Mohawk Gardens Public School in 2001 and 2003 respectively with the eldest now in grade six (in her final year) and the youngest in grade four at the time of writing. My involvement with the school spans almost eight years. More notable is the fact that I have been involved in the creation and development of the Healthy School initiative and continue to play a main role in advancing the school's commitment to engaging in Comprehensive School Health. Having spent the majority of my working career in health – first on the care side and most recently and for longer, on the health promotion side, I believe that health

promotion / disease prevention is of paramount and urgent importance and that a Comprehensive School Health approach is worthy of consideration at every school.

My introduction to Mohawk Gardens Public School actually took place before my children were born and attended school there. In 1992, my husband and I moved to Burlington, Ontario, a city of approximately 164,500 people, located in southern Ontario between Hamilton and Toronto on the north shore of Lake Ontario. One year after arriving, we purchased our house in Southeast Burlington, an older more mature area of Burlington, close to the Oakville border. To get to know the area, we would go running in the neighbourhood and would pass, what we thought at the time was a recently closed-down school. This oddly-shaped building (which to this day reminds me of a space station), had a dirty, old sign presenting the name of the school, overgrown bushes blocking the view of one of the entrances to the building and part of the sign, and chipping paint from the soffits. The fenced in Kindergarten area, located beside the front entrance to the school, had cracks in the black top and was surrounded by a dirt area most of the way around the perimeter. Two small circles of dirt on the front lawn contained a few plants, large rocks and one tree with a memorial plaque, all overgrown with weeds. The back of the school had broken basketball nets, a black top area which was uneven and cracked, an old rusted tether-ball pole sticking out of the ground (with no tether-ball) and bent and rusted bike racks even further to the back of the building next to the dumpster.

We soon came to learn that, in fact, the school was operating and served students from grades Senior Kindergarten to five. Having no children at the time, we did not think much about it other than to wonder what the future of the school might be. Given the

external appearance for all the community to see, what might the inside possibly look like?

In 2001, seven years after my “run-by” introduction to Mohawk Gardens, I had an opportunity to catch my first glimpse inside the school. I attended an open house for parents of children starting Junior Kindergarten and received my first formal introduction to the school and the education system - an event that I regarded with both anticipation and ambivalence. I was excited about the new world my daughter was about to enter and this new stage of life, but was intimidated by the school setting and an education system known for its politics and bureaucracy and for the unique passion that it evokes in its many stakeholders.

I think that passion, if not stirred prior to walking into the building, must be awakened at the first mention of the journey on which one’s child is about to embark! As I listened to the Principal and Junior Kindergarten teachers welcome the parents and provide all the information needed to help us navigate through our first year in the school system, I was overwhelmed by my own responsibility in this journey.

I listened to the information during the formal presentations from two perspectives – that of parent and of professional. As a parent, I was interested in the day to day routines to which the children would grow accustomed, the formal learning environment with its expectations, and the benefits of socialization that Kindergarten provided. As an individual committed to and a professional working in health and physical activity promotion, I was struck by the fact that no mention was made of this school’s role in the children’s health and well-being. At the same time, I thought about the physical environment of the school including my first impressions related to the

external setting and now my impression of the inside environment. The orientation took place in the library, a warm, welcoming room that had the feel and appearance of a sunken living room with stairs leading down from the school's main hallways and surrounded by bookshelves and lively decorations. The cozy feel of the library, however, could not entirely disguise the rest of the school's aged and tired interior, which most noticeably included the make shift partitions throughout the building (with boxes stacked on top and underneath) to give individual classrooms privacy and soundproofing. Despite these and other signs of aging, such as worn carpets, floors and lockers, the classrooms themselves were creatively decorated and welcoming.

At the end of the formal presentation, I sat down beside the Principal and asked about initiatives in which the school was involved to promote physical activity and healthy lifestyles. She described some traditional school activities such as play days and fundraising events (Mohawk Gardens is the longest running participant in Burlington of the *Jump Rope for Heart* fundraiser for the Heart and Stroke Foundation, a tradition started by and continued in memory of a beloved former Principal at the school). She also told me that the school had implemented Quality Daily Physical Education (QDPE) and for their efforts had received a number of QDPE awards as evidenced by the banners and plaques displayed in the front hall entrance to the school. I asked her if there was an opportunity to consider some additional activities promoting physical activity such as a *Walking School Bus* program. She was receptive to the idea and asked me to follow up once the new school year was under way.

After a few months into this new school year, I began attending School Council meetings and met a number of dedicated parents and teachers committed to making the

school a place where the children could thrive academically and socially. Health, however, was not considered or discussed to any great extent. At one of the meetings, I asked if Mohawk Gardens had considered a snack program for the staff and students. In fact, they had attempted to start a program in previous years, but a survey sent to parents to determine their interest and support revealed surprising results. Some parents took the idea of a snack program as an insult to their parenting – interpreting the suggestion as a solution to parents not feeding their children healthy food. As a result, the idea was abandoned. One parent on School Council, however, agreed that it was a worthy program and supported the idea of revisiting the possibility. With encouragement from the Principal and other Council members, we put together a volunteer committee which I chaired and began to develop the snack program. I was significantly involved in planning and implementing the snack program which involved hosting a series of meetings in the evening, completing grant applications, putting together a list of, and purchasing necessary equipment, finding volunteers, soliciting donations and securing sponsors, designing a menu, communicating with teachers and parents, organizing grade four students to serve snack, and organizing a launch event. With the support of the administration, teachers, parents, Public Health Nurse, and the *Halton Food for Thought* coordinator, we launched the snack program in March 2004, approximately two years after the first suggestion was made to revisit the program.

Given the overall enthusiastic support from the school community, we continued the program in the following 2004-05 school year. In the mean time, a new Principal began at Mohawk Gardens and had been briefed about the program. He spoke to staff and volunteers about the initiative and agreed to support the program. At the end of his first

school year, he approached our committee and suggested that we take over one of the rooms in the school as a permanent home from which the snack program would operate ... a suggestion readily welcomed as we were going to make that very same suggestion!

Involvement with the snack program has had its tribulations, particularly related to ensuring food safety given food allergies, and securing volunteers. For example, a small number of parents at one time suggested that action wasn't swift enough in taking food items off the snack menu when an allergy was suspected. I was accused by one parent of trying to kill her child when he suffered a minor allergic reaction to what she believed was exposure to a peanut product, despite the fact that the child neither ate the product nor came into contact with it. While a snack program in and of itself is neither unique nor comprehensive in addressing the broad determinants of health, and despite some minor obstacles and challenges, this program remains the hallmark of our healthy school initiative and provided the impetus to move toward a more Comprehensive School Health approach.

The picture of Mohawk Gardens is quite different in 2008 than when my husband and I initially ran by the school. A number of changes have taken place. Since my daughter started at Mohawk Gardens, I have had the opportunity to be involved in a number of activities that have taken place at Mohawk Gardens. Over a four-year period (2002-2006), I chaired a number of different committees, sometimes as many as five at a time. It became cumbersome and frustrating as it was difficult to secure people's time to attend meetings, particularly when meetings were held in the evening. Parents would most often come, but rarely would the teachers attend. After a number of iterations I proposed two committees and they currently exist in the form of a *Healthy School*



*Steering Committee* and a *Healthy School Parent Committee*. The Steering Committee is comprised of parents, teachers, administration and the Public Health Nurse. Its mandate is to determine the overall direction of the healthy school committee using a Comprehensive School Health framework. This committee is writing a strategic plan and is involved in policy development. Committee members also generate ideas for programs and implement some of them. The Parent Committee is responsible for generating and implementing programs, activities and events. This committee focuses on five main areas: physical activity; healthy eating; environment; positive school culture; and safety. I currently act as chair of both committees.

I advocated for and coordinated a number of different physical activity programs. For example, *Walk to School Day* began in 2002 and continues to take place on the first Wednesday of October. We typically began these events with a special guest walker (e.g., an Olympic athlete, an RCMP in red serge) that included an opening ceremony with a school walk. Over the years, the event has become less publicized as a result of my decreased involvement (having returned to school) however, it continues to take place on a smaller scale. The school encourages *Walking Wednesdays* and has been enthusiastic about participating in other activities such as a *World Record Walk* and a *Marafun* (walking marathon where children walk 40 kilometres, six weeks prior to a set day and then walk/run the last two at an organized event coordinated by the school) proposed by another parent. I purchased and secured a donation of pedometers for class and family walking and organized recess boxes for all classes, which decreased to boxes for each division due to the time it took me to purchase and stock the recess boxes.

One of the initiatives of which I am most proud is the development of a healthy school policy. Its creation has influenced healthier food choices in the school by having pop and chips removed from the pizza day menu and encouraging healthier fundraisers. Further, all community events hosted by the school include healthy food choices and physical activities. It has not always been popular with parents, students or teachers and was criticized by some as an attempt to take the fun out of school. I think part of the criticism is reflected by a lack of communication on the part of our healthy school committees. Although every effort is made to communicate the health message to the students, there have been times when I felt real despair over people's reactions to our initiatives. For example, I accompanied a grade four class to swimming lessons. After the lesson, some students with money wanted to buy junk food from the recreation centre's vending machine. I asked the children to refrain because the choices were poor and not all of the children had money to spend. A small number of children became very angry, to the point of yelling at my daughter and harassing me in front of her. It was a disheartening experience, but one that strengthened my commitment to enhance the educational component of our initiative and better engage students in the process.

I advocated for more inclusion on school teams, and as a result some have been renamed "clubs" in order to include and support more children. In recent years, I presented the idea and have taken on the challenge of advocating to the Board of Education and the City of Burlington the need to build a second gymnasium at our school or to build a recreation centre in Southeast Burlington.

Adopting a Comprehensive School Health approach has been serendipitous to a large extent. It has been about taking advantage of opportunities as they came rather than

forcing them into a logic model or process. It has been an emergent process with my initial vision as a guide that eventually began to find its way into a formal CSH framework that has given it structure and organization. CSH continues to be a focus at Mohawk Gardens and I continue to be involved. The work that has taken place at Mohawk Gardens to implement a Comprehensive School Health approach has been extremely rewarding. While other schools engage in Comprehensive School Health, I believed that Mohawk Gardens had a story worth sharing with the hope of encouraging other schools to consider this approach at their school. Completing my Master's degree has given me the opportunity to tell this story based on the experiences of those who are involved every day – the parents, teachers, students, administrators and community members.

I have written about the role that I have played as a parent and volunteer at the school because it situates me within this research study. At this point, I make the transition from parent volunteer to researcher in order to give a voice to those who participated in this study and share their story. Chapter four will provide the research process undertaken to collect their stories.

## CHAPTER 4

### RESEARCH PROCESS

This chapter addresses the research process which includes the research methodology and the research method. The methodology describes the philosophical stance which underpins the rationale connecting the methods chosen to the outcomes desired (Crotty, 1998). Finally, the method describes how the data was collected and analyzed in order to answer the research question.

#### Research Methodology

In order to describe the characteristics of one school's Comprehensive School Health initiative, and to explore the experiences of the school community members in order to gain an understanding of how one school embraced the Comprehensive School Health approach, a qualitative research process was undertaken. Qualitative research is based on the premise that individuals construct reality through interaction with their social worlds (Patton, 2002). "Qualitative researchers are interested in understanding the meaning people have constructed, that is, how they make sense of their world and the experiences they have in the world" (Merriam, 1998, p. 6).

As a result of using traditional qualitative methods of data collection, such as interviews and observations, the qualitative study tells a story with such rich description as to position the reader within that story. Further, these traditional methods provide the researcher with an opportunity to have close, direct contact with the people in the study, often in their own environments, to benefit from an in-depth understanding of their realities (Patton, 2002).

*Ethnographic Methodology*

Ethnography is a type of qualitative inquiry (Patton, 2002), although it is sometimes used interchangeably with qualitative research in general (Merriam, 1998). What distinguishes ethnographic research from other approaches is that it focuses on understanding meanings by examining social setting, actions, and interactions and that it is from a cultural perspective that interpretation and application of the findings takes place (Patton, 2002). Merriam (1998) acknowledges that culture is defined in many ways yet offers that the critical underpinnings of culture are behaviour patterns of a specific group of people that are influenced by beliefs, values, and attitudes. D'Andrade (as cited in Merriam, 1998) states that

To say something is cultural is—at minimum—to say that it is shared by a significant number of members of a social group; shared in the sense of being behaviorally enacted, physically possessed, or internally thought. Further, this something must be recognized in some special way and at least some others are expected to know about it; that is, it must be intersubjectively shared. Finally for something to be cultural it must have the potential of being passed on to new group members, to exist with some permanency over time and across space. (p. 14)

The use of a Comprehensive School Health approach advocates a cultural shift of the organization and the people within it. Put another way, the Comprehensive School Health approach is not just about using schools as a way to teach children about health, but rather establishing a culture where health is implicit, or seen as the foundation upon which, to support children, their families

and the external community. It is a culture within the school and radiates from the school to the community with a reciprocal benefit. It is about actions and interactions that take place both within the school and external to that school. The role that culture plays in the school setting withstanding, the focus of this research was to describe the characteristics of one school's Comprehensive School Health initiative, and to explore the experiences of the school community members in order to gain an understanding of how one school embraced the Comprehensive School Health approach. Therefore, my research was undertaken through an ethnographic case study, borrowing from a number of ethnographic techniques such as interviewing, observing participants and analyzing documents (Merriam, 1998). An important aspect to an ethnographic approach is the researcher's participation in the day to day activities over an extended period of time; that is, conducting research in the natural setting (Patton, 2002).

### *Case Study*

Case study is defined both as a process and a product (Merriam, 1998). Stake (1995) subscribes to the philosophy that case study is an object or product, rather than a process, "the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (p. 2). Case study uncovers "the sequentiality of happenings in context" (p. 2). While both Stake and Yin agree that real-life context and complexity are seminal components to case study, Yin (2003), believes that case study is a research strategy, and is, therefore, the process, linking it more closely with the scientific method and theoretical testing.

The case study approach to qualitative analysis constitutes a specific way of collecting, organizing and analyzing data; in that sense it represents an analysis process. The purpose is to gather comprehensive, systematic, and in-depth information about each case of interest. The analysis process results in a *product*: a case study. Thus, the term *case study* can refer to either the process of analysis or the product of analysis, or both (Patton, 2002).

There have been criticisms of the case study method. One criticism is that based on the small number of cases studied, the results are not generalizable and to take it one step further, the study is difficult to replicate. Yin (2003) argues that “case studies ... are generalizable to theoretical propositions and not to populations or universes” (Yin, 2003, pg. 10). Stake’s (1995) belief is that case study is an important methodology when we are either interested in one specific case or when we feel that looking at a particular situation may provide a way to gain some general understanding. That said, however, Stake points out that the obligation of a case study researcher is to understand this one case itself; to focus on “particularization not generalization” (p. 7) and value its uniqueness.

Case studies are criticized for the length of time they take and the number of documents they generate (Stake, 1995). This same criticism may be viewed as one of the strengths of case study. Like ethnographic research that uses multiple methods (Patton, 2002), data from interviews, observations and documents helps to provide a thorough look at what Stake (1995) refers to as an “integrated system”. Considering the strengths and weaknesses, Merriam (1998) summarizes the rationale for choosing case study:

The case study offers a means of investigating complex social units consisting of multiple variables of potential importance in understanding

the phenomenon. Anchored in real-life situations, the case study results in a rich and holistic account of a phenomenon. It offers insights and illuminates meanings that expand its readers' experiences. (p. 41)

In this research, an ethnographic case study was conducted to examine a Health Promoting School in Ontario. The intention was to provide a rich description about one school's Comprehensive School Health initiative and to explore the experiences of the school community members in order to gain an understanding of how one school embraced the Comprehensive School Health approach. With Comprehensive School Health as the context, a single case design was chosen, with the single case being the school. Together, with interviews, observations and document analysis, the data contributed to a holistic, complex system. While a socio-ecological model was used as the conceptual framework upon which Comprehensive School Health was based, the intention was not to evaluate this single case study against this theory but rather to provide an orientation to the study.

A final methodological consideration that guided the field work was the identification of sensitizing concepts - information and ideas that provided initial orientation to the field work as a starting point of reference (Patton, 2002). They "serve to guide initial observations as the evaluator ... watches for incidents, interactions, and conversations that illuminate these sensitizing concepts in a particular program setting or organization" (Patton, 2002, p. 279). The sensitizing concepts that guided my field work (See Appendix C) are foundational definitions and descriptions of health promotion and Comprehensive School Health –



important individually and given their inter-relationship within the health promotion context.

### Research Methods and Procedures

The following section outlines the data collection procedures including case selection; research site; gaining entry and consent; data collection methods; leaving the field; data analysis and trustworthiness.

#### *Case Selection*

While I contemplated conducting my research at a different “Living School” in another neighbouring community, the selection of Mohawk Gardens Public School as the single case study was based on a number of considerations. First and foremost, as a health promotion professional and as a volunteer at the school, I believed that the Mohawk Gardens experience was one that should be shared given the time dedicated to instituting a Comprehensive School Health approach over a seven-year period. Further, the school was addressing a number of topics and initiatives by attempting to address CSH in its broadest sense, using the socio-ecological model and the elements of Comprehensive School Health from the Consensus Statement (CASH, 2006).

I used a purposive or purposeful sampling strategy. According to Merriam (1998), “purposeful sampling is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned” (p. 61). Stake (1995) considers a number of other factors to consider when selecting a case that I applied to the selection process. The most important factor is to choose a case, in this case a school, that will maximize learning and that will provide the

greatest chance of increasing understanding. Secondly, time in, and access to, the research site are often limited. Researchers must be able to get to and from the location in a timely and cost-efficient manner both during the data collection phase, and possibly after the initial research has been completed. This was the case with Mohawk Gardens, located one kilometre from my house. It was also beneficial to choose a school that welcomed my research and supported my presence in the school during the research period. This receptivity greatly enhanced my access to the school within the timelines I established for this research. In this case, the Principal and teachers were welcoming and supportive. I sent out a letter to parents explaining the research and inviting feedback, but did not receive any feedback.

### *The Research Site*

Mohawk Gardens Public School is located in Burlington, Ontario, a city of approximately 164,500 people. Burlington is located in southern Ontario between Hamilton and Toronto on the north shore of Lake Ontario and is the largest of four municipalities in the Regional Municipality of Halton. Over 85% of the population speaks English and the average family income is over \$90,000 per annum with employers including food processing, packaging, electronics, transportation, and environmental sectors, to name a few. Burlington boasts many festivals and events which most often take place in the downtown waterfront park. The Bruce Trail and Niagara escarpment offer outstanding hiking trails. The Waterfront Trail encourages walking, running and cycling, and the city offers four indoor and two outdoor pools, three splash pads, seven ice pads, and six community centres (City of Burlington, 2006).

Situated in a mature neighbourhood in southeast Burlington, Mohawk Gardens Public School was built circa the 1960s as an open concept school, where most primary and junior classes were called “pods” and were separated only by book shelves and free standing dividers. It was built in a U-shape with the library in the centre and a small gym at the bottom of the “U”. An outdoor, fenced-in area for kindergarten students is located at the front of the school, just outside of the main entrance, while the back of the school features portables (the number varies year to year from two to five), a black top area, and a large field that merges with a city park and a field belonging to the adjacent Catholic school. Given the land shared with the city, the school has access to two baseball diamonds and a creative playground. The school is surrounded by single dwelling houses on all sides of it.

Mohawk Gardens was originally one of two public schools serving elementary students within approximately one kilometre of each other. The two schools were eventually amalgamated with students moving to the current site and the school adopting the names of both of the original schools. Today, in 2009, the school serves approximately 475 children from grades junior kindergarten to six. Students attending Mohawk Gardens Public School are predominately white and English-speaking children from middle-income families. The school also serves children in low-income housing to the east with a growing mix of new immigrant and multi-cultural families. Based on enrollment, Mohawk Gardens has two administrators, two support staff, approximately 28 teachers (including French, music and library/Physical Education), five educational assistants and three custodians.

### *Gaining Entry and Consent*

Gaining entry to the research site involves two steps. The first entails securing the permission and support of the gatekeeper or decision-maker to conduct the research and the second part is the actual physical arrival in the field (Patton, 2002). In order to conduct this research, ethics clearance was required from both Brock University Research Ethics Board as well as the Research Advisory Committee at the Halton District School Board (Halton District School Board, 2007). Brock University approval was granted on May 4, 2007 and within three days the application (including recruitment materials, consent materials, data gathering instruments, feedback letter, and other required documents) was submitted to the Halton District School Board (HDSB) for permission to conduct my research.

The Principal of an elementary school in Oakville, Ontario was approached by the Chair of the Research Advisory Committee at the Halton District School Board (HDSB) to seek permission to carry out this research. The original intent was to conduct the research at a school known as a “Living School”, a designation bestowed by the Ontario Physical and Health Education Association (OPHEA) to a school that is engaging in health promotion, with a specific focus on physical activity and healthy eating initiatives. During the process of applying for Brock University ethics clearance, I was informed by HDSB that both the Principal and Vice-Principal of the Oakville school would be transferred to another school at the end of the school year (prior to the September that the research was to start). Since they were critical to the research both in terms of process and content, this school was eliminated as an option.

Based on this information, a consultation was held with my thesis committee to discuss the possibility of conducting the research at my children's school where I am the Healthy School Coordinator. With their approval, I provided a Letter of Invitation describing the research proposal (See Appendix D) to the Principal at Mohawk Gardens Public School located in Burlington. Following a personal visit to discuss the research, I received the Principal's permission to conduct my research at Mohawk Gardens. Subsequently, permission was received from Halton District School Board on Sept. 20, 2007.

Having secured ethical approval and the approval and support of the gatekeeper—in this case the Principal—to conduct my research at Mohawk Gardens, I asked for the opportunity at a staff meeting to introduce the research to the teachers and to discuss any questions or concerns they may have. Given that the majority of teachers were well acquainted with me as the coordinator of the Healthy School initiative, I provided only a brief introduction of myself, spending the majority of the time describing the research being conducted. I indicated that I would be inviting a sample of teachers, students, parents, staff and community members to participate in interviews and that I would be requesting their assistance in choosing students. I also discussed the timeframe of the research and that I would be spending one to two days each week on average at the school doing observations. At that time, I invited them to contact me privately if they had concerns about any of the data collection methods described. At the end of the fifteen-minute presentation, there were no questions or concerns raised at the meeting. Further, I did not receive any phone calls or emails expressing any concerns. A few days after the

meeting, I sent a letter home to parents describing the research and the potential involvement of their children (through interviews and observations).

To obtain consent to collect data from observations and interviews, I sent a letter to parents introducing myself as both a parent at the school and a graduate student conducting research. The letter indicated that I would be in the school conducting interviews and observations and that I would be looking at public school records and documents. The letter stated that the permission procedures required in order to involve children in the research would be carried out in accordance with the Board of Education policy (See Appendix E). Further, specific letters of consent would be provided if they or their child were to participate in an interview (See Appendix E).

While anonymity was not possible, all participants were informed that they would not be identified by name nor would personal information from school records be used. Pseudonyms were used to identify individuals and ensure confidentiality. The letter stated that information collected during the study would be locked in a filing cabinet at my home as well as stored on a separate computer CD. Further, data would be kept for approximately two years from completion of the thesis, after which time the written documents would be shredded and the CD destroyed. Participants were informed that access to this data was and is restricted to myself as the principle investigator and members of my thesis committee.

Finally, in communications with parents and teachers, I explained the benefits of the research to me personally (as a graduate student), to the health promotion field, and to the school. Benefits to the school included being selected to share the story of Mohawk Gardens as well as the benefit that the research could have to help forward the CSH

initiative at the school. School community members were made aware that this research was being conducted for the purposes of completing a graduate level degree and that the research could be published. I urged people to contact me with any questions or concerns, but did not receive any calls or correspondence from parents. In appreciation for their participation, individuals who participated in an interview received a \$5.00 gift card to either a coffee shop or a book store and the school received a donation of recess equipment.

### *Data Collection*

In order to collect data, multiple methods, which are hallmarks of ethnographic research (Patton, 2002; Merriam, 1998) were used. The data collection process included ethics approval, participant interviews of parents, teachers, administrators, support staff, students and community members; observations; and document analysis.

### *Interviews*

Interviews provided an important source of data given the volume of data obtained. Twenty-seven informant interviews were conducted with teachers, former and current administrators, parents, students, support staff and community members. Table 1 in the Data Analysis section provides a categorization of participants. Participants were primarily considered key informants (Patton, 2002), selected to be interviewed because they had direct involvement with the healthy school initiative or had been associated with the school for at least seven years, the time period during which the healthy school initiative began. Other participants had indicated that they were aware that the school was engaged in healthy lifestyle initiatives and in some cases were somewhat adversarial towards or disinterested in the initiative. Participants were both male and female with the

majority of participants being teachers. However, groups of participants represented the different groups whose involvement with the school are integral to CSH: the individuals (students); influencers (teachers and parents); representatives of the organization or institution (administration, support staff); and the community (community members).

*Interview Protocol.* Interviews were conducted primarily at the school, with some taking place at my home (four parents, one teacher and two community members) and at the homes of four of the participants (one student, parent, administrator and teacher). The location of the interview was determined based on the participant's availability and what would facilitate the interview taking place. Interviews at the school took place in a variety of locations including the snack room, the Principal's office or a teacher's classroom. Students were interviewed in a room adjacent to the library with the door open. One student was interviewed at his home. Interviews were conducted at all different times including before, during and after school hours as well as two taking place in the evening and on a weekend (See Appendix F).

Prior to the beginning of each interview, adult participants received an explanation about the interview process, after which they were asked to sign an informed consent (See Appendix E). Students who had been asked to participate in an interview were sent home with a Third Party consent form (See Appendix E), prior to the interview, which included information to the parents who were then requested to sign on behalf of their children. At the interview, students were asked to sign the form as well. Having received verbal and written permission from participants, interviews were tape recorded and transcribed by me directly after the interview was concluded (in most cases). Each of the interviews lasted an average of 60 minutes with student interviews lasting closer to 30



minutes. Permission was obtained at the time of the interview to communicate with the participant again to ensure accuracy of the original interview.

*The Interview Guide.* A general interview guide approach was used in designing the interviews (Patton, 2002). This approach was chosen for a number of reasons. First, it provided an outline of the issues to discuss with participants in order to ensure some basic consistencies between each of the interviews and in order to ensure that all topics were addressed. While the interview guide provided specific topics and attempted to use as many open-ended questions as possible, it had within it some flexibility to explore a topic further while also looking for opportunities to be spontaneous and conversational (Patton, 2002). The development of related probes facilitated the initiation of the conversational approach. Some of the participants had time constraints based on when the interview took place. For example, some teachers were interviewed during a lunch break or prior to school starting. Given these time constraints, having an interview guide provided me with the ability to gauge my time based on the questions to be answered as well as a way to focus the discussion. Finally, as a novice interviewer, I felt this approach would provide an opportunity to develop some interview skills by engaging the participants in a conversation related to the general topics, but with the security of having questions to guide the interview keeping in mind the purpose of my research. Appendix G provides the interview guide used for the adults (teachers, parents, staff, community members) and Appendix H provides the guide used for students.

Interviews began with a general conversation and some background questions. For example, teachers were asked how long they had been teaching, how long they had been at Mohawk Gardens, and what subjects they most enjoyed teaching. Students were

asked about their families, their favourite activities and whether or not they had any pets. Once we had a chance to settle into a short conversation, I began the interview by asking them to describe their vision of a healthy school. Students were asked to pretend that they were the Principal for the day and in that role, how would they make the school healthier. Most interviews ended with participants being asked to provide advice to their peers about how and why they could engage their school in a Comprehensive School Health approach. After I turned off the tape recorder, participants were thanked and provided with a small token of appreciation for their time.

A number of issues arose related to the interviews. After the first few interviews, some questions were modified slightly when it appeared that some of the questions were not well understood by participants or made them feel unable to or uncomfortable in answering them. For example, one of the questions asked about the role they played at the school in relation to Comprehensive School Health. Many felt they did not play a specific role or were uncomfortable talking about the ways in which they did contribute. In terms of process, one aspect of the interview process that I would change in a future study is to have given the questions to participants ahead of time. Only a small number received the questions ahead of time and that was based on whether or not they requested them. Participants may have felt more comfortable with the questions and may have had time to consider their responses had they had time to review the questions prior to the interview.

A number of questions elicited contradictory responses. These differences provided me with an opportunity to further explore the topic with the specific interview participant as well as to discuss the different notions with participants interviewed at a

later time. All were considered in the data analysis and reflected in the findings. Finally, teachers were asked to identify students to participate in the interviews due to the fact that they were more familiar with the children and more likely able to determine which children might be comfortable speaking with an adult with whom they were unfamiliar. One consideration with this approach is that the teachers may have had a propensity to select students they felt would provide a positive image of the school or those who were perceived to be more involved in school activities.

### *Observations*

Having met with the Principal and staff, and after sending home a letter to parents outlining my research, formal observations began at the end of October 2007. However, whenever I had an opportunity to be in the school, I continued my observations until the end of the school year.

Given my role as parent volunteer and Healthy School Coordinator for the past seven years, I was accustomed to being in the school and being recognized by teachers, students and other parents, therefore, my presence in a researcher role went mostly unnoticed. However, in keeping with the spirit of an ethnographic approach (Merriam, 1998) I chose to engage in overt field observations (Emerson, Fretz & Shaw, 1995; Patton, 2002) and I assumed the role of partial participant in the setting (Emerson, Fretz & Shaw, 1995), by interacting with the students, teachers, and parents. As an insider, I continued to participate in a number of school activities during the three months in the field including attending three school council meetings, assisting with the dance-a-thon fund raising event, accompanying three classes on field trips, chairing meetings for two

different healthy school committees monthly, and implementing healthy school initiatives.

Observations took place initially three times a week, lasting usually three to four hours each time. Once interviews were under way, less time was spent observing unless there was an activity or event taking place at the school. Occasionally, during the weeks when I was engaged in interviews, I attempted to visit the school during different times of the day for shorter periods of time so as to observe what happens throughout the school day. Observations took place on school property, both inside of the school and outside, as well as while on school trips or during community events at the school. Inside the school, I spent time in classrooms, in the gymnasium during physical education classes, inside the library which is a gathering place for school community members given its central and open location, in the office and in the snack room. I spent only a short period of time in the staff room as I felt uncomfortable being there given my role as parent within the school.

Observations were, at first, based on the sensitizing concepts identified for this research. Specifically I looked for an indication that the four elements of CSH were present. In doing so, observations focused on the physical setting or the physical attributes of the school such as location of bike racks and overall cleanliness of the school. Important to the physical setting were attributes such as physical space (size, functionality, lighting, colours, sounds, objects in the school and placement of objects). Appendix I features some of the characteristics of a health promoting school that helped guide the observations.

I observed the social setting and instructional lessons including planned program implementation activities and structured interactions (e.g., classroom activities, physical education classes, meetings, and events); and informal interactions and unplanned activities (e.g., nutrition breaks and recess times). I also observed the relationships between school community members before, during and after the school day as well as the role of health and other community services that interacted with members of the school. Although there was some overlap with the four elements of CSH, I used the five strategies of the Ottawa Charter as a guide and based my observations on whether or not activities at the school supported those health promoting strategies. For example, I observed the interventions that supported school community members in developing personal skills. As my field work continued, I began to shift my observations to focus on the interrelationships between components of the CSH approach and interrelationships between members of the school community, rather than the physical setting.

### *Document Analysis*

Documents provide information that cannot be observed and that may not be able to be obtained through an interview (Patton, 2002). They may have an historical significance and include information unknown to the evaluator (Patton, 2002). Uncovering information through document analysis may uncover inconsistencies between what is on paper versus what is practiced. They may spark further questions or observations to be made during the field work phase (Patton, 2002). The use of documents does not rely on gaining cooperation from human participants and it is, therefore, often readily available (Merriam, 1998). Analyzing documents is non-obtrusive; thereby taking away the risk of altering the research setting (Merriam, 1998).

In terms of the weaknesses of document analysis, they may be neither complete nor accurate (Patton, 2002). In some cases, certain records may never have been kept at all and some may be kept confidential.

Both ethnography and case study rely on multiple methods to provide a more comprehensive description of the topic being studied (Patton, 2002; Merriam, 1998). A number of different documents were used to supplement the information provided through the participant interviews and observations. Documents were collected over the course of the four month period. Document analysis took place primarily during the final month of my field work (January 2008) with the majority taking place after coding my interview data.

Documents were obtained and sampled in two main ways. First, I met with the Principal and requested public documents that were related to healthy school from a program or policy perspective, and that included a broad range of topics such as physical activity, healthy eating and bullying prevention. I also searched the school website and to a lesser extent the school board website and looked at web pages on both sites. The school website is much smaller and therefore I was able to look at all web pages. Given the size of the HDSB website, I looked specifically at health related pages.

Over 100 documents were obtained. All were skimmed to ascertain their completeness and relevance to Comprehensive School Health. Approximately 50, containing 650 pages were read in detail. Documents included school newsletters/notices sent home to parents from the school; agendas, notes and minutes from School Council meetings; agendas, notes and minutes from Healthy School Committee meetings, newspaper articles, Board of Education documents; the school's policy and procedures

manual, the school's web site, school lessons and assignments, financial records and budgets, classroom and school bulletin boards, and the school effectiveness plan (See Table 1).

Second, I looked at all of the documents that were developed specifically by or in support of the healthy school initiative, again comprised of program and policy-related information as well as correspondence and foundational records (e.g., the establishment and procedures associated with a program or committee). It is critical to note that I wrote the vast majority of the documents related to the healthy school initiative as the chair of the Healthy School committee. Examples of those documents included some of the notices sent home to parents (but not all), agendas and minutes of healthy school committee meetings, planning documents, the healthy school policy, grants and proposals, and correspondence, among other documents.

Despite having been the author of many of the documents analyzed, reviewing them provided an historical context for this research about which I was unclear and was not well known to many of the interview participants. Going back through the documents provided an opportunity to consider some of the inconsistencies between what is on paper and what has been practiced at the school. For example, the policy document created in 2005 was used to observe whether or not some of the statements set out in the policy had been enacted and whether or not interview participants reflected on any of those policy areas (with or without knowing a policy existed). Many of the documents provided some context to interview findings, such as the issues related to the new Daily Physical Activity mandate in Ontario that many of the teachers discussed.

One of the weaknesses in the documents obtained was their lack of completeness. For example, minutes were not always officially documented or complete given the workload of those involved in taking them or ensuring that they were distributed. Given the volume of data, and the timelines I had in which to complete the research, I did not apply the same rigorous coding system as was used for the interviews. Rather, having established the codes through interview analysis, I marked certain passages or entire documents with labels highlighting the categories and themes to which they were related. In analyzing the documents, consideration was given to the possibility of identifying additional categories and themes, however, no new categories were identified.

### *Field Notes*

Just as field work is a critical part of an ethnographic approach to research, writing accounts describing experiences and observations noted in the field is of equal importance (Emerson, et al., 1995). According to Emerson, et al. (1995),

Writing fieldnote [sic] descriptions, then, is not so much a matter of passively copying down “facts” about “what happened”. Rather, such writing involves active processes of interpretation and sense-making: noting and writing down some things as “significant,” noting but ignoring others as “not significant,” and even missing other possibly significant things altogether. (p. 8)

Field notes were made during every visit to the school and were often written after arriving home from the school. They began primarily as a physical description of the school. Once I felt more comfortable in the setting and in the researcher role, I began to make notes about actions and interactions that I observed taking place among the



people in the school (teachers, students, parents, etc.). I wrote about the ways in which my observations supported the four elements of CSH as one of the sensitizing concepts. I also used my field notes as a reminder of what else I wanted to observe during the next research day and why. Towards the end of my formal time in the school, I wrote about some of the interpersonal observations I made, experienced and heard about and reflected on how those related to the emerging themes from the multiple methods of data collection.

On several occasions, while in the field as a researcher, as a mother picking my children up for school, or a community member volunteering, I had the opportunity to talk to school community members about various issues. I used jottings (Emerson, et al., 1995) and memos (Patton, 2002) as a way to note their thoughts and ideas. I sat in healthy school meetings and took notes or jotted down issues that were identified throughout the course of the meeting. In order to avoid writing during the conversation, I wrote down responses once the interaction had concluded.

Jottings were also made during the observations and directly afterwards, and a research journal was kept from both an organizational perspective as well as to record personal feelings and reflexive thoughts. These served as an audit trail of information.

### *Leaving the Field*

According to Patton (2002), the length of time a researcher spends in the field is often determined by the researcher's resources, interests and needs. These three criteria were relevant in my decision related to establishing the dates and time frame that the research would take place. While few financial expenses were incurred to conduct the research, a lack of income was an issue that had to be considered. I returned to work at

the end of four months of field work. At that point, I used all opportunities (on average, once a week) to visit the school and continue my observations and to read and analyze all of the data collected.

While observations at the school could have continued much longer as the school is always engaged in different activities and serves, in some ways, as a hub of the community, interviews began to yield few new themes. The themes remained consistent over the course of the four months and I anticipate that they would not have changed had I stayed in the field longer.

My role in this research was that of an insider, given my intimate involvement with the school prior to and during the research. While during that four month period I was there primarily to conduct my research, I continued to do some work on the healthy school initiative and worked in the same ways that the people in the school were accustomed. At the beginning of January, 2008, I informed the Principal that I would be concluding my research at the end of the month. We were in the midst of planning a large community meeting so my role as volunteer, rather than researcher, was more obvious to the school community, thus making my exit from the research role quite subtle. Given that my involvement at the school would also continue after the research concluded, I did not see that there would be any impact on the relationships formed. In fact, most of the relationships already existed in different ways prior to me doing my research.

### *Data Analysis*

The challenge of qualitative analysis lies in making sense of massive amounts of data. This involves reducing the volume of raw information, sifting trivia from significance, identifying significant patterns, and

constructing a framework for communicating the essence of what the data reveal. (Patton, 2002, p. 432)

As a first step in making sense of the data, I transcribed the interview tapes and interviews were recorded verbatim. Once an interview was transcribed I sent the document to the interview participant and requested that he/she review it for accuracy and take the opportunity to add any additional information as needed (Patton, 2002). For students, I sent a note home to their parents requesting that they review the transcript with their child to reflect accuracy. Just over half of the participants replied with only one adding information.

Verbatim interview notes were placed in a chart format with three columns: one for the verbatim interview transcript, one for a shorthand code beside the passages, and a third column for researcher comments. Thirty-one codes were established (See Appendix J), consisting of three parts including a code for the question, the participant's initials, and a descriptor. I read each interview two to three times and passages were highlighted with a colour and corresponding shorthand code.

Codes were established using both a deductive and then inductive process (Merriam, 1998). From a deductive perspective, the coding system and the subsequent identification of categories were developed by using a priori categories identified by using the elements of Comprehensive School Health<sup>2</sup> based on the Comprehensive School Health Consensus Statement prepared by the Canadian Association of School Health and the research questions.

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<sup>2</sup> Since the original writing of this thesis, Teaching and Learning is now referred to as *Instruction*, Health and Other Support Services is known as *Preventive Health Services* and Supportive Social Services is called *Social Support* (<http://www.cash-aces.ca/index.asp?Page=Consensus>).

While the essence of qualitative research is based on an inductive design, that is approaching the research without any preconceived notions or with the intention of proving or even making any assumptions (Patton, 2002), a number of categories were determined based on knowledge from the literature and were guided by some of the research questions. At the same time, a number of emergent categories and subsequent themes were identified using a Constant Comparative Analysis (Merriam, 1998). Constant Comparative Analysis involves comparing data to determine similarities and differences within individual interviews, by comparing quotes from different participants and between different types of data (Merriam, 1998). Therefore, as I reviewed the data looking for the a priori categories (Patton, 2002), I also looked at the data for emergent categories and themes. In some cases, the interview participants defined the categories (emic analysis) and in other cases, I developed the label for the category (etic analysis). For example, a priori categories included “Instruction”, “Teaching and Learning”, “Supportive Physical Environments”, and a category that I called “Social Support” and that was made up of a number of sub-categories, with some again determined by the literature, and some emergent. Emergent categories included *staff buy-in*, *communication*, *attitude and behaviour change*. The final stage of data analysis involved the identification of themes which served to synthesize all of the data with the overall intent of elucidating the characteristics of this health promoting school.

Documents and observational fieldnotes were analyzed and certain passages or entire documents were marked with labels highlighting the categories and themes to which they were related. While reviewing documents that I created may be deemed a potential source of bias, it is acknowledged that all researchers must examine their own

perceptions and strive for neutrality throughout the research process (Patton, 2002).

Trustworthiness will be discussed later in this chapter. At the beginning of this section, I discussed many of the reasons for analyzing documents as part of the research process.

**Table 1. Participant Categorization**

<b>Date Collection Method</b>	<b>Participants / Type</b>	<b>Produced</b>
Interviews	3 Administrators <ul style="list-style-type: none"> <li>▪ 2 Principals (1 current and 1 former)</li> <li>▪ 1 vice-Principal</li> </ul>	47 pages
	10 Teachers <ul style="list-style-type: none"> <li>▪ 5 primary</li> <li>▪ 3 junior</li> <li>▪ 1 physical education/library</li> <li>▪ 1 kindergarten</li> </ul>	130 pages
	5 students <ul style="list-style-type: none"> <li>▪ 1 x grade 1</li> <li>▪ 1 x grade 2</li> <li>▪ 1 x grade 4</li> <li>▪ 1 x grade 5</li> <li>▪ 1 x grade 6</li> </ul>	35 pages
	2 support staff <ul style="list-style-type: none"> <li>▪ 1 custodian</li> <li>▪ 1 secretary</li> </ul>	24 pages
	2 community members <ul style="list-style-type: none"> <li>▪ Public Health Nurse</li> <li>▪ Food for Thought coordinator</li> </ul>	27 pages
	5 parents Children: <ul style="list-style-type: none"> <li>▪ 2: Grades 5 and former student</li> <li>▪ 3: Grades 5, SK, pre school</li> <li>▪ 1: Grade 3</li> <li>▪ 2: Grades 3 and 5</li> <li>▪ 2: Grades 1 and 3</li> </ul>	72 pages
	<b>Total: 27 interviews</b>	<b>Total: 335 pages</b>
Observations	<ul style="list-style-type: none"> <li>▪ Physical environment</li> <li>▪ Social environment</li> <li>▪ Planned program implementation activities and structured interactions (e.g., classroom activities, physical education classes, meetings, and events)</li> <li>▪ Informal interactions and unplanned activities (e.g., nutrition breaks and recess times).</li> <li>▪ Relationships between school community members</li> </ul>	42 pages (approx.)

<p>Documents</p> <ul style="list-style-type: none"> <li>▪ Include documents available to me since 2001.</li> </ul>	<ul style="list-style-type: none"> <li>▪ School newsletters</li> <li>▪ Notices sent home to parents from school</li> <li>▪ Agendas, notes and minutes from School Council meetings</li> <li>▪ Agendas, notes and minutes from Healthy School Committee meetings</li> <li>▪ Newspaper articles</li> <li>▪ Board of Education documents</li> <li>▪ School's policy and procedures manual</li> <li>▪ School web site</li> <li>▪ School lessons and assignments (as shared)</li> <li>▪ Financial records and budgets</li> <li>▪ Classroom and school bulletin boards</li> <li>▪ School effectiveness plan.</li> </ul>	<p>650 pages (approx.)</p>
		<p><b>1,027 pages</b></p>

### *Trustworthiness of the Data*

Trustworthiness is a term that refers to rigour in qualitative research (Sparkes, 1998; Patton, 2002). According to Lincoln and Guba (1985), there are four trustworthiness criteria (credibility, transferability, dependability and confirmability) each with a number of techniques that help achieve data trustworthiness in a qualitative study.

Credibility, a concept that describes the extent to which the data collected accurately reflects the various realities of the issue being studied, was addressed in a number of ways. This research took place over a prolonged period of four months, with an additional five months being in and out of the school with opportunities for observation ensuring prolonged engagement in the field. This gave me an extended opportunity in which to look for consistency between interviews and observed behaviours as well as ongoing behaviours. Triangulation of sources and methods was accomplished through using three different data collection methods (interviews, observations and analysis) and a number of different data sources to collect information such as parents,

students, and teachers. The concept of triangulation is based on the premise that, whether using different sources, methods, or even investigators, there are many angles from which to see, a problem or phenomenon (Patton, 2002). I conducted member checks by returning all transcripts to the interview participants for verification and received just over half of them back. While conducting member checks was done for the purposes of correcting any errors and allowing participants to provide additional information, Morse, et al. (2002) caution using member checks arguing that, in fact, that it threatens validity rather than supports it.

In order to address transferability, an important concept if one wants to demonstrate that one's findings can be applied in another context, I provided thick, rich description of the case context and setting. I detailed my experiences and the experiences of others in the setting. Further, I reported my reflexive account and observations and reports by participants, and provided extensive detail through verbatim quotes that gives voice to participants.

Dependability refers to the ability to demonstrate that the study's findings are consistent and could be replicated. This was achieved in a number of ways. For example, I used multiple methods to collect my data. An inquiry audit took place by keeping all interview and observational notes. All documents have also been kept. My thesis advisor has had an opportunity to see some of the interview transcripts. Purposeful sampling was used to select the school because of its commitment to taking a Comprehensive School Health approach with support from school community members. I had the ability to identify a school committed to the initiative and tell its story in detail. Finally, I protected participant confidentiality by giving interview participants pseudonyms given that



anonymity could not be provided. Further, the participation of individuals in the research was not discussed with other participants or members of the school community. Interview files were locked in a filing cabinet at the researcher's home and electronic files were saved on a separate CD.

Confirmability ensures that the findings are informed by the participants rather than the researcher. Detailed management and recording of data addressed the issue of confirmability. For example, I used and kept verbatim transcripts, field notes, my journal and records of contacts and interviews. Morse, et al. (2002), again, caution that while use of an audit trail provides a record of decisions made, it does not necessarily indicate that those decisions were the best choice for the research. Reflexivity is also a technique for trustworthiness and is addressed in Chapter 6.

In the following chapter, I will discuss the findings.

## CHAPTER 5

### FINDINGS AND DISCUSSION

This chapter is presented in two sections. First, the findings from the interviews, observations and documents that contributed to this research study are presented in order to tell the story of Mohawk Gardens School. The second section elucidates the themes that emerged from the data and discusses them in relation to the Comprehensive School Health literature. My intention with this research is to describe the characteristics of one school's Comprehensive School Health initiative and to explore the experiences of school community members in order to gain an understanding of how one school embraced the Comprehensive School Health approach.

### FINDINGS

In order to tell the story of how one school embraced and experienced CSH, I have presented those practices that one might expect to see in a health promoting school by making the obvious, obvious. In order to do so, I considered the research questions and the four elements of CSH defined in the Comprehensive School Health Consensus Statement as a guide.

#### Implementing Comprehensive School Health at Mohawk Gardens School

The following section presents the findings related to the Physical Environment, Vision, the Practice of Comprehensive School Health, and Recognizing Challenges and Celebrating Success.

*Implementation: Physical Changes at the school*

The picture of Mohawk Gardens is quite different than when my husband and I initially ran by the school in 1992. The black top at the back of the school and in the Kindergarten area was repaired and today features black top game markings including several themed-hopscotch games, three four-square games, foot hockey courts, and a “race track” in the Kindergarten area for the special tricycles. The Kindergarten area has new play toys, a shed to neatly store all the new physical activity and gardening equipment. The space also features a KinderGARDEN – areas of flower beds with perennials and decorative stones as well as two planters with seasonal plants and bird houses hanging from the trees. Some years the trees are decorated for the holidays with popcorn and berry strings and donated decorations. The space was created primarily through volunteer time and donations as well as a small grant from a local horticultural association.

At the back of the school, basketball nets were replaced and recess bins with different types of physical activity equipment to suit children of all ages have been replenished. The creative playground was expanded with specifically selected fitness-enhancing components. The driveway and parking area was re-designed but, unfortunately, it remains a significant safety hazard. The bike racks (still old) were moved to the side of the school in the main black top area. Students and parents most often commented on moving the bike racks. According to one parent

*We moved the bike racks into a more prominent space and saw a huge increase in bike riding to school because not only were they visible and*

*students were aware of them, the bikes were also safer because it was out in the open.*

Parent, grade 2 student

With the intention of beautifying the school, an environmental sub-committee conducted a walk-about at the school and identified a number of ways the school could be made more attractive. As a result, all around the school, the soffits were painted and two urns with seasonal foliage welcome visitors entering the front doors of the school. A new, clean sign has replaced the old one and the overgrown bushes were removed in order to put in a new garden with the main feature being a memorial tree and stone remembering a grade four student who passed away in 2006. The old tetherball poles were removed as were other safety hazards. Further, security cameras connected to a closed circuit camera were installed both indoors and outdoors around the school property and connected to a screen in the Principal's office. While the majority of parents and teachers discussed the external appearance, one parent commented that

*... the school has changed in its appearance from the outside. It's becoming more and more beautiful to look at as you drive by.*

Parent, grade 5 student

Inside the school, a significant physical change was the conversion of a spare, multipurpose room with dirty worn carpeting and tired dark paint into a bright vibrant space for the school's snack program. The Principal used School Board funds to remove the carpeting from the room and lay new tiles while the caretaker secured some free paint which enabled one volunteer to repaint the room during one weekend. A *Food for Thought* grant provided the snack committee with the ability to purchase brand new equipment, counter tops, a sink, dishwasher, a table and chairs, and other needed

supplies. Bulletin boards were mounted on the walls to display menus, volunteer notices, etc. A coffee maker, kettle and microwave for volunteers were purchased and a new fridge was donated. The room was decorated and toys and books were donated and made available for children to use while their parents were volunteering at the program.

The most major and meaningful improvement to staff, students and the rest of the school community was the addition of walls inside the school. The first permanent wall was put up between the main hallway and the computer lab. That wall now boasts a beautiful mural of people running. The mural was created in a paint-by-numbers style by one of the teachers and then painted by the students. Two years later, the school is no longer an open-concept design. Each classroom is surrounded by walls and has adequate ventilation.

*Having the walls is a God-send because we can do some QDF [quality daily fitness] in here. We'll do QDF in here this morning first thing and we won't be bothering the other classes ...trying to write a test ... Now you can just do so many more things.*

Grade 5 teacher

*I think it's just gotten better and better at our school. I think there have been a lot of things at our school done to make it feel better, made it cleaner, we've had walls up which is a huge thing for the school and to support student learning. That's been absolutely massive.*

JK/SK Teacher

While the erection of walls has been the most significant change according to almost all of the participants interviewed, other physical changes to the building were also noted through interviews, document analysis and observations. Lockers were

painted, years of stored boxes with old files that sat atop the classroom dividers and shelves were discarded and old, dirty carpeting and certain areas of flooring were ripped out and replaced with new flooring. Classrooms are beautifully decorated and welcoming as is the main foyer and office area of the school. Bulletin boards in all areas of the school were decorated and now highlight student achievements including “Marvel award” recipients. Also added were two memorial areas for one student and the custodian who passed away during my time in the field. Participants representing each of the categories (e.g., parents, teachers, students, administration and support staff) almost unanimously agreed that the school is clean and tidy and the impact has benefited the school community from an academic, psychological and social perspective. One teacher remarked that

*... the cleanliness of the building, the amount of organization, respect for where things go in the building and how things work and the upkeep of the building and those kinds of things I would say have increased immensely over the years ...and I think as we made the building a better place to be, it has instilled respect for things from the parents and the children as well so that pride builds.*

Grade 3 teacher

This view was also voiced by custodial staff:

*This building has improved so much it's unbelievable. This place is an institution now. Before it was nutty and so noisy. Now you come through here in the day and it's quiet.*

Custodian

*Implementation: The Impetus to Engage in Comprehensive School Health*

In order to describe the characteristics of this health promoting school and understand what the concept of Comprehensive School Health meant to members of the school, the following describes the impetus and maintenance of commitment to the process.

In general, a number of factors describing the driving forces behind the initiative were discussed by interview participants. They included the leadership provided by me as a parent volunteer with professional experience in the field, supported by the introduction of the DPA mandate, the media, and the role of the school's current Principal.

While there had been a past history with the Lions Club whose *Skills for Growing* initiative focused on building a safe and welcoming school, the significant push towards becoming a health promoting school seemed to have been as a result of my efforts as a parent with an interest in, knowledge about and passion for the initiative. Participants described the role that they felt I had played, however, based on interviews and my knowledge of the field as noted in my journal, whatever role I may have played quickly dovetails with simultaneous events taking place on a local, provincial and national level. For example, many participants referred to news reports about the rise in childhood obesity and physical inactivity as being important to having increased their awareness of health issues affecting children. In Ontario, the Liberal government had a clear health mandate and as such, implemented Daily Physical Activity (DPA) as a way to increase physical activity during the school day. Because it is mandated, and assuming there is some accountability (or will be) for its implementation, schools must comply with the mandate. Teachers at Mohawk Gardens have, for the most part, embraced DPA.

While the former Principal was a key player in paving the way for Comprehensive School Health to begin, it was more often attributed to the efforts of the current Principal who has not only continued to support the initiative but has become one of the driving forces behind it. As a result of all of these efforts, members of the school community had more exposure to the concept and slowly began to embrace the notion of being a healthy school.

*I think the big stimulus was you as far as school council and stuff but, I mean you were the front runner as far as getting the school going – again it took one person to get it going and to hammer and chisel away at it because the old administration thought it was a good idea but just didn't have the vision or the drive to get it done and they kept delaying and deferring it and then once the new administration came in, and he had his visions of his own and then bought into it, then things started rolling and look where we are now ... and then once all the stuff like Supersize Me and all the obesity articles and all the health institutions coming out with those articles about childhood obesity, diabetes and all that stuff – maybe I think the timing was right. Maybe you were just a little bit ahead, prior to it and then all of a sudden it just starts to kick in.*

Parent, grades 2 & 5 students

*I believe the impetus was parents who cared [nods at me]. Parents who were very willing to become actively involved to not only volunteer themselves but also to advocate with the administration and with the*



*council and I think it's been a message that has been put forth very positively and therefore it has been received positively. I don't think you can change a mind set of a school by being critical of what they do. You know schools develop over time and the culture has been ingrained for a long time and it's not a wrong culture, it's just maybe time to move to a different culture. So I think the approach of the key people – whether they're key people on council and the administration together as a team is to approach it as a very positive next step rather than a criticism of what's been done in the past.*

Parent, grade 2 student

*This is such a huge thing that needs everybody to be responsible to make it make a huge difference ... so I think what you've done is you've started a process that probably nobody else would have started. We kind of all know that it's a good thing but it's extra work and you've started the process. You've started the ball rolling. You've gotten people excited about it. You've pushed it on some people and gotten them on board [laughs] and you've done what you needed to do because it's your thing.*

Grade 3 teacher

### *Implementation: Defining the Vision*

Interview participants were asked to reflect upon and share their vision of a healthy school and how they would define Comprehensive School Health. They were also asked to consider how their vision of a healthy school compared with Mohawk Gardens. Every participant talked about healthy eating and physical activity as the foundation of a healthy school. In terms of healthy eating, a snack program was

considered crucial as were healthy lunches brought to school by students. According to the grade two student interviewed, “The people come in and have healthy lunches and all the teachers would say ‘that looks like a healthy lunch’.” Most of the participants singled out the issue of pop and felt that it should not be served during the school day. Many also envisioned a breakfast program available to all children and healthy food options for fundraising and special lunch days. In many cases, participants equated healthy school with the snack program. Physical activity, the other key component to a healthy school, took the form of daily physical activity and physical education, adequate facilities and equipment to support daily physical education/activity, a Physical Education Specialist, children equipped with running shoes, an active recess programs, intramural sports and clubs, and support for active transportation to and from school. Parents specifically felt that policies supporting in-line skating and skate boarding to school, as well as a space to store equipment would be important. In their vision, walking or riding a bike to school would be the norm, rather than being driven.

While some mention was made of the physical environment, and a place where children and parents can become more knowledgeable about health, the other most common thing that people envisioned in their healthy school was a culture of respect, emotional well-being and positive social interaction.

*I'd go at it from lots of different angles but I think my initial feel of a healthy school is just the general feeling of well-being. Aside from the physical side and the food and all that, just how are people in the building, how are they feeling? How are they interacting with each other? What's the tone that is set in the school? And that's huge because I think if you*

*don't have a feeling of, I guess peace within the school and a feeling of wanting to be there, then it doesn't matter what else you're going to bring to it because you've got to have that good feel inside, so THAT is huge for me. ... You have to have that initial feeling – a good feel about the school, and hugely among the staff - because if the staff aren't happy and feeling healthy, like mentally healthy and about things, nothing is going to fly.*

JK/SK Teacher

As was reflected in their collective vision, interview participants described Comprehensive School Health as addressing physical activity and healthy eating, but in most cases looked more broadly at the importance of additional topics to be addressed, such as respect/bullying and the environment. Furthermore, they spoke about the many layers to Comprehensive School Health – the role of parents, the impact of the community, the complexity of reaching all members of the school community, the time that was required to build and embrace a Comprehensive School Health model, and its integration into the fabric and culture of the school.

*Well, healthy I suppose in terms of physical fitness, fit of mind, fit of spirit in terms of being able to feel you can come to school and be treated with dignity. I think it looks busy. It looks like there is noise and interaction at the school, kids playing, hands up, kids thinking, smiling, interchanges going on, community involved in the school, be that parents, extended community like grandparents, volunteers, agencies.*

Administration

*Holistic, individual, body, mind, soul. What are you doing for your body today? What are you doing for your mind today? What are you doing for your soul today? Of course, you know, there's so much these kids walk in with, where they're not ready to learn but if you can gently encourage them that this is a good place to understand it's a good place to calm down and really think body, mind, soul. How and what are you going to do today for yourself?*

Grade 6 teacher

Many commented on respect as a long standing foundation attributed to the well-established staff and parents who had been involved with the school for many years. It was from that foundation of respect that many acknowledged that while there was not 100% commitment from all members of the school community, there had been much progress to at least engage the less receptive in all-school activities and events as well as to encourage them to abide by some of the decisions reflected in the school's healthy policy.

*I think that it is going to take time to bring all the groups together... so that they can see that when they DO get together and work towards that same goal that they are going to have more of an impact and it's kind of the impact of you know what you're looking at down the road. ... we have to give it some time because you know they say that change – to affect a change can take anywhere from they used to say 3-5 years. It's more like 5-7 and that's if you're coming along well. You have to be patient with it because sometimes you have those set backs ...*

Administration

Most of the participants, when sharing their vision of a healthy school, began to talk at some point during the description about what takes place at Mohawk Gardens. Participants highlighted what they felt worked and did not work. The adults specifically talked about what they would do to overcome the challenges in their healthy school. When I asked them to compare their vision of a healthy school with Mohawk Gardens, many said that their vision was based on what they had experienced at Mohawk Gardens. That is, interview participants thought that the school was very close to their vision of a healthy school and commented on how it had come a long way in the past few years towards becoming healthier.

*Mohawk Gardens has done a fantastic job over the last several years moving towards a healthy school. The administration are supportive for the most part and the school council have taken on a commitment to supporting healthy school initiatives and the healthy school vision, mission. The Healthy School Committee at Mohawk Gardens is fantastic and I think one of the more popular parent group activities. Parents seem to feel quite strongly about it, although we never have enough volunteers of course to do everything, but I think ... to be quite honest, I'm quite thrilled to have my daughter at Mohawk Gardens – from again what I've seen. I think the fact that there are no junk food fundraisers. There are no chips and pop. Changes have been made over the years towards, modeling and demonstrating and practicing what the messages are. You cannot be contradictory or hypocritical because kids pick up on that right away. ... So I think at Mohawk Gardens, we're addressing healthy school on a*

*number of levels but even hearing some of the students talk about healthy school, it's starting to come through – the messages are starting to be reiterated back.*

Parent, grade 2 student

Finally, although not well communicated according to some of the interview participants, Mohawk Gardens has written a Vision Statement and a Mission Statement for the school. From the Mohawk Gardens Draft Policy Statement (2005), the Vision reads

*Mohawk Gardens Public School will be recognized as a school where children and their families thrive academically, physically, socially, and emotionally. The children and families of the Mohawk Gardens Public School Community will be the healthiest in the City of Burlington by ensuring that a healthy, active lifestyle is part of its daily culture.*

The Mission statement reads:

*Our mission is to support and provide every student with opportunities to improve their health and well being on a daily basis in order to establish a foundation for academic achievement, healthy growth and development and lifelong health.*

### *Implementation: Practicing Comprehensive School Health*

The practice of Comprehensive School Health is based on a complex model previously described that requires a school to focus on activities such as instruction, programs, supportive environments, and policy development; the roles of the actors and how they interact; and a number of topic areas. Given the volume of data, I have tried to

focus on the major *a priori* and emergent categories, while taking into consideration the complexity of the model.

### *Teaching and Learning (Instruction)*

As one of the four elements of a Comprehensive School Health approach, instruction is comprised of a number of areas. Through participant interviews, I found that informal learning opportunities, the role of the teacher, training for educators and curriculum were decidedly crucial factors to the CSH approach based on participant interviews. Most often discussed by all categories of participants were the informal learning opportunities provided (meaning not part of the curriculum) and the role of the teacher.

In terms of an informal learning opportunity, one of the most consistent topics that was discussed by interview participants and supported by the documents, observations and historical knowledge was the snack program. Second to that were physical activity initiatives. All participants described the impact that the snack program has had as a teaching tool for students, teachers and parents alike. In fact, the broader topic of nutrition was very prominent in the responses, observations and documents including food related to class parties and school events, external programs in which the school participates, and the use of nutrition breaks to discuss what children brought to school to eat and to encourage children to eat their healthier options first.

*I believe we as educators have a significant role to play there. I will not pick on, or I will not use one child's snack as an example, however, if I note something with pop or things that are not as healthy, I'll simply, in our health talk, say "let's think of other options that you could use".*

## Grade 6 teacher

*The snack program gives kids ideas because to them, maybe 'hmm, oh, that's good for me so maybe I should do it at home and it really tastes good, so maybe I should do it at home'. One time for instance, they had the pitas with the apple and cheese, I made it at home once and I loved it. I said, "Mom, this is really good" and so she tried it and she was like, "It's really good"... I think it would make the families say "maybe you should start eating healthier" and eating healthier matters a lot.*

## Grade 6 student

I observed the snack program in operation on several occasions during my fieldwork. Approximately three to five volunteers arrived in the snack room just after the bell rang. After consulting the bulletin board to determine the snack for the day, one volunteer checked any packaged foods for traces of allergens (peanuts primarily) and then rechecked the packaging with the Principal. Once the snack was reconfirmed as safe, the volunteers began preparation of the snack. Preparation involved not only cutting up the food but also setting out the trays for each classroom which were identified by a tag with the teacher's name and the number of people requiring a snack in that classroom. This could include students, the teacher, an educational assistant, a student teacher and parent volunteers. Trays were also prepared for the staff room and the office. Five minutes prior to the start of the snack time, grade four students arrived at the snack room to pick up the tray for the class to which they were assigned. There were two students per classroom, with the exception of the grades five and six classes. One student from each of those classes picked up his or her class's tray. Once snack was complete, teachers or



students returned the tray to the snack room at which time the volunteers washed the trays, tidied the room and noted any issues for the coordinator.

I also had an opportunity to observe the children in their classrooms when the snack trays arrived. They were served the snack by their class volunteer and sat to eat their snack. If there were leftovers, they were allowed more food if there was enough for everyone who requested more. In talking to the students, they explained to me that the snacks were delicious and healthy and that they looked forward to snack day.

Physical activity was the second most-often mentioned activity to take place at the school that all participants talked about and felt that the school played an integral role in engaging children by providing education about and access to opportunities. It was the most often observed behaviour that I saw during my observations.

*Teaching the kids to be more active in terms of showing them how to be active. I think that's a big thing. Like if I just say, "You guys need to be active", it's kind of like saying, "Play nice out on the playground". Well if they don't know what play nice looks like, so ...teaching them, showing them how to be active, teaching them about healthy eating and not to scare them but even teaching them the ramifications of not being healthy.*

Grade 1 teacher

Informal teaching opportunities were viewed not only as the provision of information but as a way to reinforce the lessons learned at home.

*I can give him the message and then I can show him that the school is trying to give him the same message so it's not just me being crazy. "I'm*

*not the only one who's trying to show you this. There are other people who are showing you this. It's not just coming from me".*

Parent, grade 3 student

School was deemed an important place for children in particular to gain knowledge and skills related to health.

*A healthy school would be one that is safe, the environment is such that ...children have the opportunity to learn about healthy eating, physical activity, that it's a rounded environment where anything coming into the school, being taught in the school is to the benefit of the children – emotionally, physically, all of those important aspects, behaviour and so on. And there's a lot of different programs and curriculum that can go around that to ensure that that happens.*

Community member

The role of curriculum was touched upon by teachers, parents and administrators, but with less emphasis than some other issues. The issue with respect to curriculum centred around the demands of time in relation to the breadth of material to teach. Specific concerns were expressed about the lack of daily physical education classes and physical education specialists. One administrator provided some thoughts at both the cause and solution for the issues expressed by teachers and parents.

*The common curriculum still allowed some integration. It moved to a period ...where things have been very siloed. So math time, now it's art time. Now it's music time ...there is a bit of a danger when we start to look at specialist teachers in elementary school... You lose the integrated model... once you start to silo and you move to more specialists and you*

*go to a rotary [model] you really break down the cohesiveness of it. It's harder then to integrate the things that could be seen as an add-on. So they'll continue to be seen as an add-on because "I'm supposed to be doing this now. Now I have to do this on top of this." "Well, no, find a way to bring it together in a more integrated approach." So as you hear teachers saying, "Well, I can do that from this perspective and now I can make it a little healthier and integrate the healthy, active living into it so it's not an add-on", it's along side of or mixed together which ultimately could bring about having a long term culture change.*

### *Programs and Policies*

Over the past several years, there has been a significant increase in activities related to program and policy implementation at Mohawk Gardens. Programs and policies extend to family members as well. A number of different committees were attempted, re-invented and eventually established in their current forms by 2005. The school has a Healthy School Steering Committee made up of three parents, four teachers, two administrators and the Public Health Nurse. Its mandate is to determine the overall direction of the healthy school committee using a Comprehensive School Health framework. This committee, which meets once per month, was in the process of writing a strategic plan and revising the policy at the time of this research. Committee members also generate ideas for programs and implement some of them. The other committee is the Healthy School Parent Committee responsible for generating and implementing programs, activities and events. This committee, comprised of approximately ten parents

that meet once per month, focuses on five main areas: physical activity, healthy eating, environment, positive school culture and safety. I act as chair of both committees.

From a healthy eating perspective, the snack program was the most well known program. It is the hallmark of the healthy school initiative. Since its inception, having paved the way to focus attention on healthy eating, pop and chips were removed from the pizza day menu, different types of lunches were tried (with varying degrees of success such as hot pasta, soups) and cupcake fundraisers no longer exist. Students and their families participate in *Families are Munching*, a vegetable and fruit tracking program as well as *Four for Lunch*, a campaign encouraging students to bring all four food groups in their lunches.

The school increased its physical activity programs through initiatives such as Walk to School events, an organized recess program, the development of a ParticipACTION club, involvement in a Marafun program, a lunch-time skipping club, a class pedometer program, participation in physical activity fundraisers (in place of selling “junk food”) and special events. All teachers received a pedometer to wear (the Principal and office staff wear their pedometers every day). Pedometers were donated by ParticipACTION for every student in the school. Family skate nights were instituted over Christmas and March breaks that included a WinterActive education component in February. Finally, some teams were renamed “clubs” in an effort to be more inclusive. A number of policies were put in place to support a healthy school. For example, special events (e.g., carnivals and in-class celebrations) must now all include healthy food options and a physical activity component.

In support of the 2005 Ministry of Education directive that mandated Daily Physical Activity (DPA), Mohawk Gardens created a teacher committee with 14 representatives, an unprecedented number for any committee to date at the school. While this was not a policy from the school's Healthy School Committee, it provided additional impetus to some of the programs that the committee was trying to implement according to most teachers interviewed. Conversely, the physical activity efforts under the healthy school umbrella provided some momentum to staff to embrace the DPA mandate and according to most of the teachers interviewed Mohawk Gardens has been one of the more successful schools to implement DPA in Halton Region.

Other programs mentioned included a free-throw competition at lunch, TV-turnoff week, with a focus on replacing screen time with physical activity, a dance club offered to students in grades four to six, and swimming lessons for grade fours that included four-one hour sessions with half of the session dedicated to lessons and half to free swim, with a commitment from the City of Burlington Parks and Recreation Department to expand the program to grades five and six students. There was a great deal of recognition of many of these initiatives:

*The physical, like getting the kids involved, I see that at Mohawk, and I see a lot of attempts in different ways to get the kids physically involved, and the teachers, to buy into it and I think there have been many efforts at Mohawk to do that in many different ways. I think to pull it off 100% all the time is a tough act.*

JK/SK Teacher

*The recess bins full of sports equipment is a very positive thing because the kids go looking for those bins. They want the balls, they want the Frisbees, they want to play flag football. They love it. And you know you've got some kids who maybe wouldn't have tried sports otherwise - their families can't afford it or they don't feel confident enough but here we have soccer balls at school, we've got footballs at school. The kids can try these sports there. So, I think Mohawk has been very positive in introducing things to kids they might not have been exposed to.*

Parent, grade 5 student

Physical activity has also been embraced by incorporating it into the curriculum. A number of teachers and students, as well as the administrators interviewed, talked about incorporating physical activity into other subject lessons. During one of my days in the school, I observed a grade one class learning patterning by using movement. When I interviewed the teacher weeks later she talked about using physical activity in her lessons:

*Oh yes, we do patterning, we do our ABCs, like when we do printing I talk about tall letters, you know like your L, so we do our ABCs on our bodies, so [describes this] and g is the basement so we try to touch our toes and try to do that faster and faster.*

Grade 1 teacher

*We did a little competition for the dance-a-thon, against 2 other classes on what class would get the most steps. So we linked it in with math. We were doing data management and bar graphs and then we compared how many steps as a class against 2 others and who did the best and we compared it*

*as well to how many kids were in the class. They enjoyed it. They loved it.*

*They like the competition, they do, but they also were recognizing the movement and what it means and using the numbers to understand it.*

Grade 5 teacher

While physical activity and healthy eating initiatives have dominated, other topics related to a healthy school have started to emerge. The environment became more of a focus with the school considering a future *No-idling* campaign. The KinderGARDEN was a way to not only beautify the kindergarten area, but to provide the children with opportunities to plant seeds and bulbs and feed the birds. Litterless lunches were encouraged and recycling efforts involved all classes.

Efforts to combat bullying have been discussed for the past three years; however they have really just begun in earnest this past school year. The Principal invited parents to participate in a special committee to address the issue and paid for committee members to attend a professional development day on the topic. Other areas of positive school culture have been addressed, however. For example, a guitar club was available to grades five and six students. While a junior choir has historically existed at the school, this year a primary choir was introduced. Two years ago, the vice-Principal introduced a talent show and it was one of the most popular activities at the school. It took place during the day but parents were welcome to attend.

Last year, one of the grade four teachers developed and hosted a class challenge during nutrition breaks. Using his Smart Board he ran “Who Wants to be a Millionaire?” “Girl Talk” a program focusing on self-esteem for girls in grade 6 was implemented by the Public Health Nurse. A partnership was developed with a community organization

serving at-risk children who may attend Mohawk Gardens. Perhaps the most ambitious activity to date began as I started my research: members of the Healthy School Committee began advocating for the building of a second gymnasium or the building of a recreation centre close to the school.

### *Contributing Roles*

I asked the participants to describe how different groups of people contribute to the development of Comprehensive School Health. Specifically the groups were government (encompassing the Board of Education as well as the Ministry of Education), parents, students, administration and school council. The role of the teacher was most closely related to their responses in relations to teaching and learning approaches above.

*Principal.* There was consensus that each of the groups contributes to the ability of a school to engage in Comprehensive School Health and, of course, that each group's actions will influence the degree to which the school can be successful. One group, or perhaps person, seems most pivotal in a school engaging in Comprehensive School Health and that is the Principal. While participants felt that children's health was ultimately the responsibility of parents with major support needed by teachers given their influence, knowledge, skills and access to the children, the Principal is the person who ultimately decided the role that the school would play in terms of priority that health would be given above and beyond the curriculum. The Principal is seen as the gatekeeper to a school engaging in Comprehensive School Health.

The current Principal discussed his approach to the school's implementation of Comprehensive School Health. In his new role as Principal, he spent time talking to parents and teachers about the work that had taken place regarding the healthy school



approach. During this process, he approved the continuation of the snack program and was aware of the committees and meetings taking place. Once he determined that staff were generally supportive and saw the benefits of the snack program, he provided a permanent home from which the snack program could operate and used school funds to clean up the room for our use. He also dedicated funds to support teacher involvement on the Healthy School committee and serves on the committee.

Over the past three years, the Principal has taken more of a leadership role and assumed ownership over different aspects of the initiative. He has also championed a number of initiatives and has helped to sustain some of the programs at a time when I had to temporarily step back. His role has included that of advocate to staff as well as parents and the Board of Education and role model to staff and students. The grade one student I interviewed summed it up best by saying, “He tells you to get active”.

When I asked him what would have happened without his support, he told me frankly, “It wouldn’t have happened”. Teachers and parents alike believed that the Principal’s role was integral to the program.

*You need to know that I had to make those decisions fairly soon after arriving here what I was prepared to support and not support. And certainly I spent a great deal of time listening to how important this was for our school, from a variety of perspectives and felt it was something I was prepared to allow to continue so I guess that’s a way to describe it or not – by allowing it to continue would mean that I wouldn’t get in the way to stop it and in the end ultimately I supported the process moving it forward in a variety of ways.*

Administration

*I think our administration is leading by example and that they are always visible on the playground. They're always out on duty. They're always wandering through the school and taking in what's happening and I think that, that all comes into play with promoting the healthy school initiative and they participate.*

Support Staff

*He is the driving force behind ensuring that we are going to stick by our word and say we are going to take a healthy incentive.*

Grade 6 teacher

*Parents.* According to interview participants, parents played a seminal role in their child's health overall and contributed significantly to the Comprehensive School Health model. Parents were viewed to be the ones to fill the gaps in the school that teachers did not have time and in some cases the mandate, to fill.

Parents played a variety of roles in the school including reading to students, playing chess, helping out in classrooms, attending field trips, checking attendance, coordinating coat and food drives, fundraising, sitting on committees, running special food days and helping to coach teams.

While teachers and parents both felt that they shared a role in influencing students and were generally respectful and supportive of those roles, there was tension between the groups in terms of where each of them felt the other group could be more supportive and where they were dropping the ball, so to speak. Parents felt that teachers could be more involved in role modeling, providing opportunities for healthy behaviours outside of school time (particularly leading intramurals), and supporting healthy behaviours

during school time such as not taking recess or physical education time away to discipline students. Teachers, on the other hand, felt that parents were often perpetuating poor health habits, particularly related to nutrition in terms of the food brought to school, and that parents should be more involved in helping out with a number of programs and initiatives as many of the opportunities to promote health fell outside of their responsibilities.

*Parents can either make things work beautifully in a school or it can hinder things from working. I think that when you get a group of enthusiastic parents and you rely on the background and the experience and the knowledge that people have, it just makes it so much more powerful ... I mean that is very powerful because these people who are coming are vested in interest in what's happening to the kids and they have all these different backgrounds and resources that you don't have as an administrator ... it really takes every body you know together working....*

Administrator

One parent was concerned about the role of the school as reflected in the following quote:

*When [name] was in JK or grade 1, he came home and said they had gone through their lunches and they were supposed to rate each item as thumbs up or thumbs down. I had made chocolate chip cookies and I took it personally because they were home made, they weren't store bought and he got a thumbs down. And I said, "That's not a thumbs down one – it's*

*maybe sideways [laugh] but it's not a thumbs down. It's a home made cookie – what's wrong with that?" So, I was totally offended.*

*School Council.* Closely related to the role of parents is that of school council.

Made up primarily of parents, school council also has teacher and administration representation and in some cases, representation from the community. The role of school council was deemed important due to their fundraising role and subsequent allocation of those funds, their mandate to advise and raise issues with school administration and in their ability to sustain the initiative. It was also noted that over the years, there has been a significant shift away from not embracing programs and topics (e.g., healthy eating) to embracing the entire concept of the school as a health promoting school, albeit with varying levels of understanding and commitment.

*The school council has enabled healthy school to exist and they promote and fully endorse the types of things we want to do and a lot of those are financial because without support from parent council we wouldn't have the release time for teachers. The school council also supports if we go to them asking for financial assistance in bringing something to the school. I think our school council is phenomenal in that respect.*

Physical Education Teacher

*There are some parents who tend to fight that a little bit so I think a strong chair who is supportive of this is important as well because they can bring to the table items for discussion. If they're not discussed then they're not going to happen. And keeping key people on council such as yourself to be the healthy school coordinator, like that role is not a*

*formal or official role in a council structure but it's one that Mohawk Gardens has put in place as a, more or less as an elected position that we continue to hold.*

Parent, grade 2 student

*Students.* The student role was one that was deemed somewhat weak at Mohawk Gardens related to the Comprehensive School Health initiative. While students were involved in some leadership roles through the snack, Families are Munching and PROPS programs, their opinions and suggestions have not been well incorporated into the decision making related to healthy school. The intention to re-instate "Kid Council" and use Healthy School as a foundation for their involvement was discussed by a few parent and teacher interview participants.

*Maybe by getting the kids involved as we do in the snack program with the grade fours, by involving them you've got three years of that student group who can maybe take on more roles in the program and therefore buy into it, feel accountable for it, responsible for it so developing that through our student population to help with sustainability.*

Parent, grade 2 student

*Government.* Finally, the role of the provincial government and Board of Education were also considered important to Comprehensive School Health, but was viewed most often as negative or the stumbling block to the whole process. Teachers interviewed felt that they were overburdened by a demanding curriculum and, therefore, had less time to focus on issues related to health; Policies with a health focus were implemented with little support or, again, viewed as an add on; and the bureaucracy of

both institutions was too cumbersome, thereby prohibiting the school from moving its healthy school priorities forward.

*And yes the Ministry has a big push these days but the Ministry has a push around lots of stuff and it becomes the school and school leadership that decides what are the priorities because we can't do everything.*

#### Administration

The dominant issue discussed by all participants focused on the recent Daily Physical Activity (DPA) mandate. Overall, DPA has been well received by this school, however, for as positive a feeling there was towards it, there were also negative feelings, particularly around it being an add-on with everything else currently expected. However, most teachers talked about the benefits they saw as a result of implementing DPA. It was also acknowledged that this government has a focus on health which was seen as ultimately contributing to help drive Mohawk Gardens' healthy school initiative forward.

The Board of Education was viewed by many participants as the institution that put up the most barriers for the school to overcome. The frustration for Mohawk Gardens, described by teachers, parents, administrators and community professionals was the blocked attempts from the Board of Education to keep the school open after hours. In partnership with a community agency, the Principal was attempting to get free access to the school's gymnasium in order to offer programs to all students, but with an emphasis on supporting the more vulnerable students in our community. The Principal on behalf of the school has been met with continuous resistance to do this.

*So, the system barriers – there has to be some political and some real system agreements in place to help us achieve Comprehensive School*

*Health at a school level. When barriers exists, such as using each other's space and then those um either related to income – someone won't get paid if you use my space, services in kind – if those things aren't sorted out from a managerial system level, it really makes a difference to the lives of the children we service because they're the ones who aren't going to get use of space the best we can.*

Community Partner

*Health and Other Support Services.* In a time of scarce public health services, Mohawk Gardens was fortunate to have some dedicated attention from the Public Health Nurse (PHN) assigned to the school (along with approximately 15 other schools). That dedicated time was based on the fact that the school served children in higher needs situations and was committed to Comprehensive School Health. The Public Health Nurse was an active and integral part of the healthy school initiative. She attended Steering Committee meetings, provided resources to staff and parents on topics such as bullying awareness and prevention, facilitated the Girl Talk program previously mentioned, introduced new programs offered by local, provincial and national organizations of interest to the school, organized and/or implemented programs such as the Bathroom Olympics, Families are Munching (a fruit and vegetable family tracking program), and other programs offered by the public health department and provided encouragement and expertise to our group!

Despite her commitment to and role within the school, only seven people mentioned public health services in the interviews. The PHN as well as the one other community-based participant interviewed and a few parents and staff associated with the healthy school initiative recognized the role of public health in Comprehensive School

Health and were consistent in their opinions. Public Health was a well respected and integral part of the healthy school initiative at Mohawk Gardens.

*We do have a good relationship with our Public Health Nurse which I think is a good community connection as well and that person can be really instrumental in providing some support for us and some resources and connections for us in all of our areas of healthy school – that could be the mental health, parental education as well as nutrition and physical education/activity.*

Parent, grade 2 student

This final quote sums up the findings about contributing roles to Comprehensive School Health as it has been experienced at Mohawk Gardens School:

*Well I think definitely the person who is the administrator of the school has to be helpful in it because you are, shall we say brokering between community parents, and teacher and student groups and um I think the thing about being open is, I mean if you know something's good for kids and you can get the community and parents to support it, that's powerful. You cannot do it yourself and anybody who thinks they can needs to get a little dose of reality. That's not the way things work. You need to bring all those parties together to support you.*

Administration

### *Link to the Community*

According to a number of teachers and support staff, Mohawk Gardens traditionally had strong links to the community including their relationship with the Lions



Club, a number of older adult homes in the area; and an institution known as Wellness House, a local hospital's day therapy program, which had space in part of Mohawk Gardens school. It served a wide range of patients with different needs. It was not uncommon to see a person in a wheelchair sitting with a student in the library. The students sang for the patients in the hospital pod or took their art work in to show them. Eventually, each group needed more space and so the day therapy program moved to a new location.

More recent relationships included one with a social service organization that serves low income and high risk families in our school community, Parks and Recreation to deliver the swimming programs and with whom the school worked to expand its creative playground, and faith groups in the area that have offered financial support to some of the school's programs.

Interview participants, particularly those involved with the Healthy School Committee, talked about the recent receipt of an advocacy grant from the Heart and Stroke Foundation, which will allow Mohawk Gardens to begin expanding its relationships and reach out to additional individuals and organizations such as city council, McMaster Children's Hospital, a local paediatrician, different departments within public health, neighbourhood seniors and day care centres and others. Further, an initiative has begun to work more closely with the community of schools.

Nevertheless, a number of challenges remain. The Healthy School Committees are attempting to have the arena across the street available for school skates to avoid bussing children across town to skate. Advocacy continues directed at the School Board to open the school's gymnasium free of charge after school, and to city council to build a

recreation centre in southeast Burlington, perhaps on the property adjacent to Mohawk Gardens where there are currently no facilities for residents.

*I think that's the point where we're at, where we're about to affect the community although we haven't done it formally yet. I think just the people involved in the healthy school committee talking about it with the people in the community who they see, I think there is already starting to be a little bit of influence and thought going on from community people. So far as public policy, whether we have influenced what's going on there yet, I don't think so, but I think it's in our reach ... we can do it! [We have to] include Public Health and the city in what we're doing and then our next big step is our advocacy in the community – it is a huge step and I'm really excited to see what happens.*

Physical Education Teacher

### *Recognizing Challenges and Celebrating Success*

To tell the story of how Mohawk Gardens started and practiced Comprehensive School Health without sharing the many challenges that it encountered would not provide the complete picture. The insights that interview participants shared in terms of challenges were consistent with my observations and field notes, journal notes, and noted in some of the documents analyzed. Challenges included lack of funding, volunteers, time, communication, and space / facilities. Competing priorities were also identified as a challenge as were community policies that were preventing the school from realizing a truly Comprehensive School Health model. The major challenges that arose were interwoven in two of the overarching themes that emerged from this data – those of

‘Capacity’ and ‘Understanding of the Comprehensive School Health concept’ to be discussed in the next section of this chapter.

Celebrating success is important in any significant undertaking. Participants were very enthusiastic about sharing what they thought was successful and what they saw as key ingredients to implementing CSH that had sparked some kind of change at the school – whether physical, behavioural, or attitudinal in nature. Of all the questions asked, this question generated the greatest number of responses.

Every single participant said that the snack program was the most successful initiative – both as a single program and as an important launching pad to the more comprehensive approach to school health. Participants said that snack has served to increase awareness about healthy choices to students, teachers, and parents. Many talked about how they are trying the snacks at home. One parent, whose daughter is a former student at Mohawk Gardens, said the healthy school initiative, but specifically the snack program and nutrition teaching had had a lasting impact as she attended middle and high school,

*[Success is] when the kids who've been at Mohawk take those healthy school or healthy living skills with them in life and to other schools. When [name] went to [School x], she said "Mom, they don't have a food drive at [School x], they don't have snack program there, they don't have QDF." The kids notice that there were things that we were doing at Mohawk that they weren't doing at the next school they went to. When [name] and her friends went to [school y] and got to the cafeteria, they were horrified at the food. The kids from Mohawk, they've learned these healthy life skills.*

Parent, grade 5, graduated students

The snack program itself was also credited with providing a healthy meal for some students who came to school with little to no food. There were also many children bringing lunches devoid of fruits and vegetables, therefore, every menu consisted of a fruit or vegetable.

*Well, I know I've had kids in the classroom who came to school with virtually no food at all for their snack or lunch, I see them at the end of snack after there was still food sitting on the tray – I made sure they got it and those kids needed that food and were appreciative of it... you could tell how much it was benefiting those kids. And also, even kids that didn't need it were introduced to foods that they hadn't tried before.*

JK/SK Teacher

According to participants, the snack program provided the impetus to address healthy eating more broadly in the school. Both the Principal and grade 6 teacher described a class party that was held. In the past, this party's menu consisted of pizza and cake and other less healthy choices. The teacher suggested veggies, fruit and dips but told the Principal it would be expensive. He gave his full support and they purchased fruit and veggies trays.

*We had the discussion around what would be provided and we really went down the healthy route so we spent \$100 on fruits and vegetables for the kids and at the time I thought well let's just hold our breath and see how it goes. The teacher got wooden skewers so the kids all made fruit and vegetable kebabs and they just ran around with their vegetable and fruit*

*kebabs and I'm standing there thinking isn't this funny ... if they didn't have the sticks, they probably thought this was the geekiest thing. I thought that was a milestone.*

Administration

*We rarely get fast food dropped off at the school.*

Administration

A number of other successes were noted such as the physical environment.

Teachers, parents and some students talked about the difference that was noticed now that the school had walls as previously discussed. There was less noise which helped students concentrate and helped teachers deliver class lessons including the ability to lead DPA at a time that was convenient and not jeopardizing another teacher's lesson. The students talked about having physical activity equipment to use at recess, the games drawn on the black top and the newly expanded creative playground.

Most of the teachers and administration and some parents and students commented on the benefits that have been enjoyed by teachers specifically as exemplified by this quote:

*I think some of the teachers have become aware at their prior lack of attention to their health and seeing some of the things and the energy we're putting into the healthy school committee, I think some of them have become more aware and have made positive changes to their health. To me, that's huge! So one of our teachers has quit smoking which resulted in a gain of weight which is natural, and now has undertaken to lose that weight and is now back down to a healthy weight ... One of our teachers has participated in a marathon since this has started and whether or not it*

*has anything to do with our healthy school committee, I don't know but I'd like to think that that person is thinking about their health. Another teacher who was previously neglecting her weight issues has looked after that and lost weight and I think has felt the benefits of being in the healthy weight range. Another teacher comes to school early and walks every day. I see the teachers participating more aggressively in QDF rather than being an observer.*

Physical Education Teacher

There were a number of general comments made about the overall success of adopting a Comprehensive School Health approach. The comments illustrated the acceptance of Comprehensive School Health as a guiding philosophy, one which is beginning to provide an overall foundation and a concept that is guiding the activities in the school.

*For example, if we don't have a lot of kids visiting the office for poor behaviour, which has been a huge change in the last few years – if you don't have a lot of disruption in your class. If you see kids being active in the school ... we're saying what's right here? And those things are right. When the school comes together when there is tragedy, that sort of thing, then you know you've got the right attitudes happening and those children must know at some level that people care about us here. They care about us here and it's the little things we do that show them that we care and I think this is one of those things.*

Physical Education Teacher

*I think we've achieved quite good success getting to the policy piece that you never gave up on and having other partners around the table and people in the community now are recognizing Mohawk Gardens. I think that at Mohawk, we did a lot of ground work, we worked at system change from a school level, we've got people on line with us, we did that internal shift – it took 5 years, but I think that's really good.*

Public Health Nurse

While not always defined as success, almost every interview participant, when asked what advice they would give to another school committee embarking on the journey of Comprehensive School Health, suggested that they take a gradual approach. Teachers in particular emphasized that taking a gradual approach was most likely what facilitated people's understanding of the concept and, therefore, their buy-in and commitment to CSH at Mohawk Gardens.

*I think the way we've done it is the way I would approach it – the gradual increase and trying to get more teachers involved in different ways so finding out what they do that they might want to start. So even if it's not an athletic club, a club of some sort, so it's healthy and social so the kids are getting some experience during school, before and after, so there's more involvement overall.*

Grade 5 teacher

One parent expressed frustration about the amount of time it took to begin implementing different initiatives and to adopt the policy as illustrated by the following quote:

*But it was a slow frustrating start, which is one of the reasons I pulled out of the school council because everything was being deferred to the next month and to the next month, there was no progress being made in some of the basic, basic things ...*

Parent, grades 2 and 5 students

When asked about the frustration that some expressed in terms of the time it takes to initiate and build a healthy school, in the context of any advice one would give, one of the administrators interviewed stated:

*Well first of all I'd tell them to start small and build their success before they grow. I think that's one of the biggest mistakes that people make. They want the whole enchilada at the beginning instead of a crumb and they need to be satisfied with narrowing this down at first*

Administration

Finally,

*I am incredibly proud of what happens at our school in terms of this committee. I think we are making some really neat changes and positive changes for the kids. ... And I think the hardest part for me at the beginning was how long it takes but change takes time and attitude change takes longer and so, am I proud? I am. I'm really proud of what I see people doing and just the little incremental changes of someone saying or let's just walk around the other way. It's a little further. We can get some fresh air. You know, teachers wearing their running shoes for physed is a nice change.*

Physical Education Teacher



The findings presented in this section help to describe the way in which Mohawk Gardens Public School has approached and practiced the concept of Comprehensive School Health. The next section of this chapter discusses the themes that help to characterize the school's overall experience.

## DISCUSSION

Delving deeper into the data presented in the findings, my goal was to make the hidden more obvious (Patton, 2002). Three main themes emerged that characterize the Mohawk Gardens experience. The first theme relates to the fundamental question about CSH which is the school community's *understanding of the concept*. The second theme I term *positive school culture* and the third and most diverse theme is that of *capacity*. The themes while listed under their own titles are not mutually exclusive.

According to Stewart-Brown (2006), "...the health-promoting schools initiative is a multi-factorial approach that covers teaching health knowledge and skills in the classroom, changing the social and physical environment of the school, and creating links with the wider community" (p. 4). The definition sounds straight-forward and clear, maybe even simplistic in terms of providing four succinct strategies on which to base a healthy school initiative. However, anyone who has been involved in building a healthy school, whether from the inside or out, can attest to the complexity of this approach. In looking at the data collected at and about Mohawk Gardens and reflecting on the ongoing process from an insider's perspective, much of this discussion will highlight those complexities.

## Theme: Understanding of the Concept of Comprehensive School Health

In addressing the emergent theme of “understanding” I first considered the definition of health and then the different ways that CSH may be understood. Is CSH a program? Is it a state of being, a philosophy? Is it a foundation? And are these mutually exclusive? I would define each in the following way: CSH as a program would make it a separate entity from other things that happen in the school, such as academic programs, extra-curricular programs (although they would may be of a health-related nature), and an add-on. Undertaking initiatives related to CSH would be considered in the context of all other opportunities presented to a school such as fundraising activities and special events. As a foundation, CSH provides the basis upon which decisions are made at the school. It is inextricably related to philosophy in that members of the broad school community value health, believe that a child needs to be healthy in order to thrive academically, physically, socially and emotionally, and hold the belief that the school has an important role to play. Health, then, is a philosophy and one foundational concept, and CSH is an approach that provides the foundation upon which to support health by addressing the complex and multi-dimensional determinants that affect health.

### *The Definition of Health*

The understanding of “health” as a foundation was most often considered in the context of physical health. Although the majority of interview participants talked about their vision of a healthy school encompassing the physical, social and psychological spheres, most teachers specifically did not view the things that they did in the school as

contributing to a healthy school unless it involved physical activity or healthy eating.

When I suggested their contributions to the school contributed to the health of the students and their colleagues, they expressed surprise at that notion. For example, there are a number of teachers who are musically inclined. One of the teachers whom I interviewed played his guitar as the students were coming into the school each morning. He also played the guitar during class and offered a guitar club for students in grades five and six. Similarly, one of the administrators played the piano and violin and provided the accompaniment for the children at assemblies and other performances both in the school and in the community (when the children sing at a nearby seniors' residence). Neither the teacher, nor the administrator, thought that their musical contributions contributed to a healthy school or a sense of well being. However, in further discussion with the administrator, she did suggest that her contribution of conceiving of and planning the school's talent show, contributed to the health of the school. These examples seemed to indicate that many teachers did not equate health and the role of the school beyond physical health to psychological and social aspects of health. Parents, however, consistently talked about health as broader than just physical health. They referred to health from a psychological and social perspective.

### *Comprehensive School Health as a Program*

Participants often characterized Mohawk Gardens' approach to CSH by the programs that were offered or the resources provided to the school. Most often the focus of adults and children, as well as the documents reviewed, were programs related to physical activity and healthy eating, with a specific emphasis on the snack program. In

fact, a few participants equated healthy school solely with the snack program or the DPA mandate.

These two topics are likely to be the most directly related to healthy school for a number of reasons. Physical inactivity and unhealthy eating are behaviours that while difficult to change are conducive to program-based interventions (Stewart-Brown, 2006). Programs and resources targeting these two behaviours are plentiful and tend to be straightforward in their implementation (Stewart-Brown, 2006). While the bigger issues of social and physical supports, as well as policy initiatives, are critical to changing and sustaining behaviour, the goal at the program level tends to be more directed at raising awareness and providing an opportunity to learn some skills (WHO, 1986). The leadership role I have taken at the school, along with my professional background and personal interest in physical activity, has shaped some of the initial direction that the school has taken. Once the snack program was under development, it was used as almost a first step to introduce physical activity programs to the Principal and school council. In the past two years, the focus has expanded from offering programs to addressing the social and physical environmental supports, policy initiatives and community engagement in the issue. According to Stewart-Brown (2006), the programs found to be most effective were those addressing mental health, healthy eating and physical activity. Specifically, programs addressing physical activity and healthy eating were considered to be more sophisticated and the most likely to address school environment and parent involvement (Stewart-Brown, 2006).

Another reason that participants felt there had been an emphasis on healthy eating and physical activity initiatives thereby reinforcing CSH as a program, was due to the

concerns about childhood obesity and conditions thought to be related to obesity which have been a constant focus of the media and health professionals. In fact, in boys, the prevalence of being overweight has increased from 15% in 1981 to 35.4% in 1996, while the prevalence among girls increased from 15% to 29.2%. During the same period, the prevalence of obesity in children tripled, from 5% to 16.6% for boys and from 5% to 14.6% for girls (Tremblay & Willms, 2001). Physical inactivity and unhealthy eating practices were believed, by participants, to play a role in rising numbers of children and youth who are overweight and obese.

As well as physical activity and healthy eating, participants felt that a healthy school should institute programs that prevented or combated bullying and promoted respect. Many of the teachers cited the *Tribes* program – a program that attempts to instill a culture of respect – as the way in which the students were taught about respect. Environmental initiatives were also cited as both taking place and needed in the future.

#### *Comprehensive School Health as a Philosophy and Foundation*

While most of the participants talked about programs related to health topics, supported by observations of different programs and documents related to the development and implementation of programs, there were many other interview responses that reflected their views of health as a foundation and CSH as the foundational approach to achieve academic, social, emotional and physical success. Many described the programs that took place during and after school hours, but most described a “feeling of being” part of a culture where health in its many different forms was valued and integrated. That culture was achieved through various program opportunities related to a number of topics beyond healthy eating and physical activity, a physical environment that

was clean and safe and supportive of health practices (such as providing bike racks, healthy food and aesthetically pleasing surroundings), the commitment of both internal and external school community members, mandated curriculum and government policies, and resources in terms of finances and volunteers.

It is important to start with our beliefs about the role of schools, which traditionally is as an educational institution, not one dedicated to health promotion (Rudd and Chapman Walsh, 1993). Health is often seen as being the responsibility of an individual or the responsibility of parents as it relates to their child (Lalonde, 1974). However, schools do have physical and health education curricula, but it is argued, have staff with limited knowledge about the topics (St. Leger, 20021).

Rudd and Chapman Walsh (1993) proposed that schools are in the business of education, not health protection and promotion. They argued that the health message is secondary and in some cases may even compete with the primary mandate of the schools as a social and education agency. Interviews with some parents and teachers revealed a similar belief to some extent. They acknowledged that while health is important and likely positively influences academic achievement, it was still an “add-on”.

*As a teacher, reading is more important than running around a track at this stage for me.*

Grade 1 teacher

Changing the social and physical environment of a school is paramount in influencing and sustaining behaviour change. It involves awareness raising, education, skill building, political will, resources, time, expertise, leadership, just to name a few (WHO, 1986). It also involves creating links with the wider community, the other aspect

of a health promoting school. It is in line with the social-ecological model that is based on the belief that individuals do not live in a vacuum, but rather as part of a bigger society that exerts positive and negative influence on them at a number of levels – interpersonally (the people who influence them), organizationally (through the institution with which they are affiliated), community (the structure and characteristics of the community in which they live) and from a policy perspective (the policies that are in place at all the different levels).

It is understandable, then, to want to address health through educational opportunities - curricula and programming. To tackle the other three aspects requires capacity. However, if we focus only on education and skill building, how do we ensure that those learnings and skills can be supported in order that health is sustained and serves as the capacity or resource for everyday living that enables us to pursue our goals, acquire skills and education, grow and satisfy personal aspirations (PHAC, 2002).

In many cases, responses related to understanding of CSH from a philosophical perspective were contradictory. Often, teachers, administration and parents spoke about health as a foundation for a long and successful life and in order for that to happen, there was a need to embrace healthy school as a culture, woven into everything done at the school. Teachers and administration most often, however, came back to the promotion of health as an add-on. If health is the foundation and one embraces the philosophy of a healthy school, then health and the ways in which it is promoted and supported must not be seen as an 'add-on'. Rather, healthy students should be encouraged because of the impact that good health has on all other aspects of life. For example, in this quote, the

promotion of health may come down to what Education Quality and Accountability Office (EQAO) scores are rather than as a way to support enhancing them:

*There also has to be the support from the person or people that will allow their staff to do those things and not necessarily it's allow or not allow, it more comes down to what are the priorities and where do people want to spend their time. So if you come into a school and right now EQAO results are becoming the be all end all for anything in education these days around any monetary, staff support focus. The Ministry is tying everything to those results. That can come at a cost to other things within the system. There has always been a balance around the importance of that versus the importance of the arts or physed or technology or everything else that's not reading, writing and math per se and so it becomes a challenge. You know, if I came into a school where the results were sitting at 20% of students who are functioning at level 3 or 4, you know I might be hard pressed to say; 'Well let's spend a good vast of our time getting everyone healthy'. I mean that could be someone's perspective walking into the building. So again, it boils down to being able to balance priorities and initiatives with some means to an end that is positive to the students.*

Administration

There was also evidence from the interviews that there was still a lack of understanding between individual responsibility and resources for health and the importance of physical and social supports.



*It's not reading and writing - which some kids may struggle with - everybody can eat healthy, you just have to choose to do so with maybe some understanding and knowledge and education around making those healthy choices, but everyone has to eat and everyone has to move.*

#### Administration

St Leger (2001) pointed out the school's knowledge of health is limited, however, he also pointed to the research that indicated a strong link between poor health and educational achievement. As a result, the education sector is beginning to understand and accept that a 'whole school' approach to health and social issues will ultimately help to fulfill their primary mandate of education.

Deschesnes (2003) pointed out that a lack of common understanding about CSH or health promotion is not uncommon and is not always seen as a problem. In fact, those who view CSH as a series of interventions (programs, initiatives) have the flexibility to introduce, adapt and sustain the concept in a way that best meets the needs of the school. This is exactly the way in which the concept of CSH was introduced at Mohawk Gardens. There was no process or steps taken as the health promotion literature would suggest. The opportunity was not presented in a way that that was appropriate. In fact, we worked at introducing one program at a time before suggesting environmental changes or a policy. As the leadership changed and teachers became more familiar and comfortable with the approach, we began to expand our initiatives and broaden our focus from simply using curricula and other programs to educate students but to reaching out to teachers, parents and the community. Deschesnes (2003) cautions, however, that this approach may dilute the intended approach of CSH with "comprehensive" and "integrated" being the key

ingredients and CSH may be linked to one particular initiative, as we experienced to some extent at Mohawk Gardens with some believing the snack program and/or DPA were synonymous with CSH.

### *The Responsibility for Children's Health*

Interview participants discussed the respect and camaraderie that characterized the relationships amongst staff and between staff and parents. Despite that feeling, there were passionate responses about who was responsible for the health of children. There were divergent attitudes about the roles that each of the different community members played and should play in the area of health. These conflicting attitudes suggest that the role of Comprehensive School Health in the promotion of health is not a shared philosophy, a critical element, I would argue, in the implementation of this approach.

According to McLeroy, et al. (1988) an important contributor to behaviour change using the socio-ecological model is the interaction between different levels within the model. In this case, in order to facilitate healthy behaviour in children, there needs to be interaction between the students in a school setting and all those who influence them at an interpersonal level.

Parents, teachers and students all agreed that parents had an overall responsibility, but that given the amount of time children spent at school, teachers and other school staff had an important role to play. However, there was tension between parents and teachers in terms of their expectations of each other. Parents were often critical of teachers about what they felt was indifference to the health of students and the provision of opportunities.

*You have a lot of teachers and administration in the system who are comfortable with the way things are, have maybe done it this way for so many years why rock the boat ... "It's not our job to teach children healthy eating." "It's not our job to make sure they're physically fit, that's the parents' job. We're just here to teach." "Well you're also here to teach them life skills, not just about ABCs and 123s. You could incorporate in your teaching the healthy living, healthy eating – it takes imagination, effort and change and there are some people not always willing to do that.*

Parent, grade 5 student and graduate

*I think you're starting to see a lot more teacher involvement at our school. Compared to when I was growing up, there seemed to be a lot more intramural activities and after-school programs and it's something that's been lacking at Mohawk. I think we're starting with the change of administration ...so there's starting to be a lot more involvement with the teachers which has been a big issue with me.*

Parent, grade 2 and 5 students

Conversely, one parent commented that she was uncomfortable having the school and/or teachers provide healthy lifestyle programs promoted to her child. She felt that the programs that promoted healthy eating were designed to be critical of how parents were performing as well as the fact that they were just one more thing to do in a day. While she felt that programs were needed to raise awareness of certain health issues, she felt she was being judged.

*I just felt like it was more work for me and I probably took it personally. I see this stuff coming home from the school and I think big brother is watching me and I realize it's not that way but I think now I'm under pressure. Now I have to start marking things down. And I have to start forcing my kid. "You have to eat your snacks. How come it came back? I have to fill out a form. Why didn't you eat your apples ...Eat them now [laughing] cuz I had to say you had 5 servings today. What will they think of me at the school?" [laughing]. We try to do it but I feel like it's more work and I do get that feeling.*

Parent, Grades 1 and 3 students

This feeling of being judged was evident in one teacher's response when she explained her concern about what parents were or were not doing to promote health, particularly related to nutrition.

*Parents are a huge [barrier]. I mean you look at the garbage that these kids bring for lunch and their snack. And like I said, I'm all about treats in moderation and I think it's important that the kids learn to deal with those treats appropriately...but these kids who have pizza every day for lunch or who have those 'Lunchables'.*

Grade 1 teacher

Comments from both teachers and administration also indicated that they felt parents had more time to come into the school to volunteer and take responsibility for healthy school initiatives, particularly where it is felt to fall outside of the responsibilities of the staff as illustrated in the following quote:

*How do I word this without offending someone? I'm here and I've got a job to do and I've got my 8 hours to try to accomplish everything that I need to do. A parent often on the parent council are either a stay-at-home Mum or they volunteer.*

Grade 1 teacher

### *The Responsibility for the Adults' Health*

Given the focus of CSH as targeting all school community members, very few participants commented on whether or not the school had a role in the health of the parents and the teachers. According to teacher reports, however, they felt they had benefited from initiatives aimed primarily at the students but did not talk about the school as having a significant role with respect to their health or opportunities from a workplace wellness perspective. Teachers, parents, administration and some students talked about teachers as role models and influencers. DPA was one specific initiative that teachers mentioned as an opportunity to gain skills in physical activity through involvement in the school's committee and through professional development in which all teachers took part. Similarly, all teachers attended *Tribes* training and others mentioned specific opportunities such as workshops on building self-esteem, bullying and safety. Many talked about their appreciation for being included in the snack program, and said that snack had become a discussion in the staff room related to what was served, how people were enjoying it, etc. but overall, the focus was geared more toward the students and their parents.

Approximately mid-way through my field work, I met with one of the teachers informally. At that time, she shared with me that she had been asked by the Principal to

lead wellness sessions with the staff. She led some at the school while another session was held as part of a retreat in conjunction with a professional development day. The purpose was to focus on the wellbeing of staff for their benefit (as opposed to providing skills that could be used with the children, although the knowledge could certainly be translated). The teacher said that the impetus for this session was based on our school's commitment to CSH.

Overall, the focus on parents has been focused on encouraging their involvement as volunteers for such things as *All Star Reading* programs, teachers' helpers (read: photocopying), snack program, field trip supervisors, event planning and community relations-type programs (e.g., food and clothing drives). From a CSH perspective, they are an important asset related to social support as an influencer of their children and other children with whom they work.

*Well, I think certainly parents take an active role in what happens. I mean certainly the goal around a lot of things that we do in the building is to have parents see the value of what we're trying to accomplish and for them to be part of the solution for their own child because ultimately we're doing it for their children. In a good school, you stay focused on what is the point of all of this ... I think as long as things are directly connected to students, people can find the value in that, they're willing to put their time in.*

Administration

Parents said they benefited from the snack ideas that their children shared with them, but did not see the school as a place where they would come and participate in or

learn about health. Our Healthy School Committee, through the Public Health Nurse, offered one-on-one sessions to parents but primarily to discuss child-related issues. They were very poorly attended, likely during their scheduled time during the day.

In this context, giving due consideration to the multiple facets of a comprehensive (multi-target and multi-strategy) intervention and the appropriate way to integrate them is a fundamental issue. The potential effectiveness of this kind of approach lies not in the success of the components taken in isolation, but rather in well orchestrated, coherent strategies, i.e. health education, public policies, and communication, which concurrently target several dimensions of health and well-being deemed to have a high priority. For that reason, it is important that the intervention focus simultaneously on children, school environment and school/family/community links using various strategies to address the multiple objectives. Because of the complexity of these approaches, the conditions that support and facilitate integration of the different facets or components of the program must be put in place. (Deschenes, 2003, p. 390)

#### Theme: Positive School Culture as Key to Comprehensive School Health

Positive School Culture emerged as a theme. It was after a series of incidents occurred during the writing of this thesis that this theme, emphasizing the “positive” aspect of the school culture, rang true. Having CSH ingrained as part of the overall culture is critical and there is much data from all three data collection methods that

elucidate the notion of culture within this health promoting school. However, and this may seem intuitive, the positive aspect has distinguished itself as a key ingredient of a health promoting school. In as much as a positive atmosphere might connote the health of a school to some extent, it is that which is required to inspire the continued leadership, motivation, creativity and energy to forward this work toward ultimate sustainability. In this section, I will touch on some of the aspects described by participants and through the *Tribes* program that build a positive school culture.

According to Goldring (2002), “Culture’s power lies in the ability to dictate everything about a group, from what it discusses to the beliefs group members hold in common and the values the group teaches” (p. 32). She outlines six traits of culture which include: (1) shared vision; (2) traditions; (3) collaboration; (4) shared decision-making; (5) innovation; and (6) communication. I will briefly discuss the findings in the context of these six traits as they relate to this study.

### *Shared Vision*

While staff, and to some extent parents, were aware of the vision at Mohawk Gardens, and in many cases, through interviews, participants described similar beliefs and attitudes towards CSH at Mohawk Gardens, I would not be able to say that they shared a vision of CSH at the school. According to Goldring (2002), it is not essential that every member buys in. The school has a School Effectiveness Plan (SEP) that guides the overall direction of the school. Two years ago, a component described as “Safety and Well-being” was added to the SEP. Decisions about activities, programs and other initiatives that take place at Mohawk Gardens are made based on the priorities of the Plan (the other two related to numeracy and literacy). Healthy School initiatives have,



therefore, had some priority based on their inclusion in the SEP and that document may help to guide the school community toward a shared vision in the future. Similarly, Mohawk Gardens' Healthy School Steering committee drafted a vision and mission statements for the school that were developed as part of the policy process. Although it has existed for the past three years, it has not been well communicated to parents or teachers. It has, however, served to guide the Healthy School (Steering) Committee. The more influential document of the two has been the SEP. While the words themselves may be less known, the expectations, particularly with teachers, are understood. The current administration at Mohawk Gardens has been very clear with respect to healthy lifestyle expectations.

*I've taken a bit of a hard line around the food that comes in the building. Still need to do a little massaging with a few people. I mean if we're responsible for serving any food for children or providing an opportunity where children are eating in the classroom, it has to be authorized by myself or by Mary and I'd say staff are really pretty good about – maybe not 100% do I know about but I should and when they need the reminders, the reminders are given.*

Administration

One of the curricular approaches to building Positive School Culture and towards establishing a shared vision is through the *Tribes* program. *Tribes* is a research-based cooperative learning model that strives to create a positive environment that supports positive behaviour, and therefore learning. All teachers at Mohawk Gardens participated in *Tribes* training that included peer support and responsibility and uses cooperative

learning strategies. Positive culture in the classroom and school is built by having students learn and honour the four *Tribes* agreements: *Attentive Listening*, *Appreciation/No Put Downs*, *The Right to Pass*, *Mutual Respect*. Each month, a different agreement is the focus. That focus is emphasized in the school newsletter that goes home to parents, on the website and at monthly “Marvel Assemblies” that celebrate the accomplishments of the school.

### *Traditions*

The notion of traditions came up frequently during the interviews and that were supported by observations and documents. Both teachers and parents talked about some of the things that happened at Mohawk Gardens that have a long history as well as significant meaning. One example was the school’s participation in Jump Rope for Heart. Mohawk Gardens school is the longest running school in Burlington to participate having recently celebrated 20 years. The initiative began as a tribute to a former staff member who died. Teachers have assumed the responsibility of leading the coordination and implementation of all elements of the event. A few years ago, school council discussed replacing the fund raiser with something more active (long-term rather than a one-day event) and more relevant to the children. After a discussion with the teacher representatives on council, the decision was made to continue with the activity and address the other concerns using a different fundraiser. A dance-a-thon was added as a fund-raising event. We realized that the event, while not completely meeting the needs from a physical activity standpoint, was a very important tradition to teachers at the school, many of whom have taught at this school for many years.

Another important tradition at Mohawk Gardens, according to teacher and parent participants, was the Remembrance Day ceremony. I had a chance to observe this ceremony as part of my research. Open to the community, the one-hour ceremony featured music, poetry and story reading, a slide show with the pictures of Canadian soldiers recently killed, and students taking part in a flag ceremony and “colour guard” ceremony. The song “A Pittance of Time” was played and two minutes of silence was observed. It was a powerful and emotional ceremony. All classes prepared by making something to commemorate the day and their work was displayed in the gym where the ceremony took place. One of the most touching moments was when the teachers got up together and sang a song, accompanied by their colleagues on the piano and guitar. This more recent tradition of the teachers singing came about after “9-11”. There were many other traditions cited in interviews, perhaps less extravagant, but just as important, such as staff themed lunches.

### *Collaboration and Shared Decision-Making*

Collaboration and shared decision-making (Goldring, 2002) are both seen in many different ways and between many different groups of people at Mohawk Gardens. The most significant example, as previously discussed was the collaboration and shared decision making that takes place through the Healthy School Steering Committee, which is made up of administration, teachers, parents and community partners. Both through interviews and observations, it was clear that the teachers, whose release time is paid for by the school, have used this vehicle to increase the awareness and interest of their colleagues in the area of school health. The impact of the Healthy School Steering

Committee has also contributed significant to the theme of capacity and will be further discussed later in this chapter.

Some teachers interviewed indicated that they did not always feel that their voices were heard with respect to decisions that impacted healthy school initiatives. Most often, they were referring to the DPA mandate which is a government directive, with school flexibility for implementation. Further, as evidenced earlier, the Principal has assumed the role of gatekeeper and decision maker in a number of instances.

### *Innovation*

Many of those interviewed felt that Mohawk Gardens was becoming more innovative (Goldring, 2002) as it related to promoting the healthy school message. A number of new programs were initiated as well as adding small twists to some of the existing initiatives. For example, the school participated in Walk to School Day for many years. Each year something a little bit different was done. For example, the first year an Olympic bronze-medal swimmer walked with the children. For the next two years, children were greeted at the school by the fire department and police including an RCMP officer in red serge. For the past two years, the school parking lot was blocked off to cars and running shoes were put in each of the parking spots in place of cars.

One of the initiatives to which interview participants most often referred was the advocacy grant that the school received in order to reach out to its family of schools as well as to the broader community. The intention was to ensure that there was consistency between the family of schools to support the work that had been done at Mohawk Gardens as children move through the system. Second, school members want to advocate for either the building of a new gym at the school or to lobby our city council to put a

recreation centre in southeast Burlington where children living in this area will have access to nearby facilities. This effort is currently in progress.

The school has had media exposure related to its innovative approach related to CSH. Examples included news stories and pictures about Mohawk Gardens' initiatives featured in the city's local newspaper the *Burlington Post* including the launch of the KinderGARDEN and the pedometer program/Marafun event, two feature stories in *Education Matters*, a Halton District School Board publication, and we have been featured in the City of Burlington's *City Talk* publication through our city councilor's report and the Mayor's report.

*I attended a wonderful and informative symposium at Mohawk Gardens Public School earlier this year with my colleague Ward 5 Councillor [name]. The message we heard there was loud and clear that parents are looking for support in the battle to offer today's youth more nutritious food options and improved access to physical recreation.*

Mayor of Burlington in an excerpt from *City Talk* publication

Attempts were made to engage students in different and creative ways but less time has been devoted to engaging students which was recognized as a weakness in participant interviews.

### *Communication*

Finally, related to these six traits is communication (Goldring, 2002). It was an area that was described by participants as lacking related to building a healthy school. Communication emerged from the data as essential to the success of Comprehensive

School Health yet was something that the school has spent a disproportionate amount of time addressing. In looking at the social ecological model (McLeroy, et al., 1988), it is important to have communication vehicles directed to individuals in each of the layers (e.g., target audiences within each layer) and communication between each of the groups represented within the layers. Communication was an emergent issue throughout the interviews and was supported through observations and documents.

Although it was acknowledged that communications required more focus, I noticed through my observations, a number of channels used to communicate healthy school messages including posters, notices and pictures on bulletin boards; a large mural of people running in the main hallway; health information provided at school assemblies; posters, books and pictures pertaining to health displayed in classrooms and in the snack room and through the display cabinet at the front entrance of the school. Documents that contained Healthy School information consisted of pages on the school's web site, school council minutes and minutes from Healthy School meetings – both of which were made public to parents on the community bulletin board and on the web site, correspondence that has gone home to specifically alert parents to an upcoming initiative or program and small sections within the parent/community newsletter.

Participants focused on the lack of commitment to communications but from two perspectives. From a more positive perspective, parents, teachers and administration interviewed, felt that the school has not adequately touted its accomplishments to members of the broader school community. From a negative perspective, committees have done an adequate job at best communicating with parents and students for the

purposes of providing awareness and education regarding the initiative itself as well as content information.

*But I would also like to have an evening where parents come in and really see what we're doing. I believe the positive change or the positive profile has to be shared and facilitated so it's the committee that can say 'here's what we've done. Here's how it looks. Here's how your child is benefiting.*

Grade 6 teacher

*The only downside I think from what we're doing is that we haven't communicated enough to our staff. I worry that we're in a little bit of a bubble and we need to be presenting a healthy school update at every staff meeting ... nobody likes to be out of the loop and you can't be on every committee but we need to educate and inform them of where we're at – "this is the stage of the policies we're making, what do you think" and bring feedback back from the committee. I think that's the only piece that we're missing.*

Physical Education Teacher

Parents and teachers talked about being inundated with information that comes home from the school, not necessarily pertaining to healthy school, but to all other aspects of school life from field trip notices to fundraising opportunities to newsletters. Teachers also received a number of memos and email correspondence to sort through and felt there needed to be a balance between sending adequate information and overload.

Another concept related to communication was the attempt at conveying a welcoming feeling to visitors and community members coming into the school. While the

majority of the participants felt that the school had a welcoming feel and that staff themselves were friendly and inviting, one parent felt that the school, as an institution, was an intimidating place and that despite having three children that are or were involved in the school system, she did not feel comfortable going into the school, other than for specific parent nights such as concerts, plays, etc. She wondered, given that she is an English-speaking, educated woman having grown up in Burlington, how other parents who are not from the country and do not speak English well would feel about coming in. The secretary whom I interviewed shared the same concerns. As the multi-cultural community around Mohawk Gardens grows, this is an area that needs to be addressed.

### *Pride*

There were a number of other concepts related to positive school culture that were woven throughout the interviews and the story that has emerged. Every category of participants interviewed talked about respect, with children using words such as “being treated nicely”. Related to being treated with respect was a feeling of being valued and acknowledging that trust and camaraderie were well established at this school amongst all community members. Parents and teachers specifically talked about feeling proud of being a member of this school community as well as of the school itself.

*As a teacher at Mohawk Gardens, I feel there is a sense of pride. I like coming to my school. I like my colleagues. I feel that we're cohesive and we support each other so that's where I get that soul piece, when I need the stitching together....so I do feel that it is a positive place to come.*

Grade 6 teacher



*I couldn't have been happier having either one of my kids go to this school. As far as this community school goes, that school is fantastic. My kids are both very aware of parents who help in the school, friends working together to make it a better place. The staff, I mean as people are very nice people. It's always very welcoming walking in there and you get a sense of a school that's relaxed and fun. You've got kids' art work up, you've got community news. You've got things that say that the school is a community school and we all work together to make it a good place.*

Parent, Grade 5 and graduate students

*I think students and teachers and parents really work well together here. I see a lot of healthy interaction on our school council. Certainly school council supports teachers. They're always amenable to ideas that teachers may bring forth. I see a really healthy dynamic there between those 2 factions.*

Administration

### *Ownership*

The idea of “ownership” related to healthy school was also interpreted as contributing to a positive school culture. Many of the teachers whom I interviewed reacted with surprise both when I asked if they were aware that Mohawk Gardens was a health promoting school and how their vision of a healthy school compared to Mohawk Gardens. In the former case, many teachers responded vehemently that they were aware – one seemed a little annoyed that I would think she wasn't – and many shared what they were doing to contribute to the healthy school approach. There were some who did not

equate their contribution to a healthy school environment, as previously discussed, however they were aware that the school had embraced CSH. Probably more overt was the ownership that seemed to be taken by the administration.

*So it's the things that teachers may choose that become part of the culture of how they do things in the building here because it's just what everyone does. So when new people come in they hopefully get immersed with that culture in a very positive perspective around 'well, ya, we're really healthy around here' or 'that won't work here, you have to do it differently now' you know and it's not necessarily me having to tell them it's just you know it's peer pressure in the positive sense of this is the culture of the school.*

Administration

#### Theme: Capacity to Engage in Comprehensive School Health

A common term in health promotion is “community capacity building” where community can refer to a group of people “united by social connections, a common identity and common goals.” (Raeburn, et al., 2007, p. 85). It is a term that could be used to describe the assets or strengths of a “community” or its challenges and deficiencies. It can also represent the community’s wishes and goals rather than those imposed by a professional or outsider. From a community capacity building perspective, Mohawk Gardens, as a community, has used a bottom-up approach. In describing the capacity at Mohawk Gardens, I will discuss both the strengths and challenges that we have encountered in engaging in Comprehensive School Health. One of the interesting things

about capacity as a theme is the juxtaposition within each of the features defined. That is, each feature identified is seen as an asset and a challenge.

### *Leadership and Champions*

One of the first features that characterized capacity, according to participant reports, was *leadership or having a champion*. Related to leadership/championing is *skills* and will, therefore, be discussed in this context. Mohawk Gardens has been fortunate to have leadership come from both parents and staff with respect to CSH. While the concept began as a parent driven idea, administration supported it and moved it forward.

While much has been accomplished through ad hoc and the different iterations of committees, the establishment of the Healthy School Steering Committee was a significant step to moving the Comprehensive School Health initiative forward. The Steering Committee is made up of me as chair, two other parents, teachers, the Public Health Nurse and the Principal. What was different about this committee from others that the school had attempted before was the commitment from the Principal to hold the meetings during school time and to pay for one teacher to be released from class to attend the meetings. This committee has evolved from having two teachers originally interested, to having four currently participating on the committee. In order to support this commitment, school council also contributes to teacher release time. The advent of the Steering Committee, then, provided an ability to meet on a regular, more frequent basis, engage the teachers (both on and off of the committee) more fully, and expand the focus from program development within the school to looking outward in addressing the community issues that impacted the healthy school initiative.

Participants interviewed felt that I had provided the impetus in getting the school to adopt a healthy school approach driven the concept of healthy school and have championed the cause. However, the main strength was having someone that had a health promotion background and skills.

*You came in and you said this is what I believe and this is what should be happening and you started talking and that's how it all came about – without a doubt. You need a person with drive, you need a person with passion, you need a person with know-how and you need a person with commitment AND you need a person with connections. That's a hard person to find and you just happened to walk in the school.*

JK/SK teacher

*I think that you are the mastermind behind the healthy school committee. You're the one who developed it and you're the one who facilitates meetings and sets all of that up. I wonder what would happen if you weren't there. It's a concern because one day you're not going to be there.*

Parent, Grades SK and 5 students

### *Social Support*

As the “mastermind” behind the healthy school initiative, and as one who has some knowledge in the area of health promotion, but at this school in a volunteer capacity, I have struggled with this whole issue of skill building, particularly as we strive to engage and involve more parents and reach out to teachers and parents at our family of schools.

One of the parents described me as “the coach” in her interview and yet I feel that I have provided very little support in terms of education or skill building related to the topics addressed or the CSH approach itself. I have provided to our Steering Committee some of the theory behind CSH, the Ottawa Charter on which CSH is based and the social-ecological model, on which our initiative is also based but have spent less time with the Parent Committee. Concerns were expressed by parents through the formal interviews and informal conversations during my observations about the lack of work that was accomplished through the Parent Committee on certain initiatives. They were describing commitments made by some parent members that were never realized. It was only during the informal opportunities to chat with people that I was informed that some member of the Parent Committee were struggling with a perceived lack of knowledge about the topic they had chosen, lack of skills to navigate through the system and lack of confidence to ask for assistance. One parent discussed her lack of confidence and knowledge about the subject areas as barriers to being more effective on the Healthy School Parent Committee. She talked about wanting to be involved and felt committed to the topic, particularly about bullying as an issue to address, however, she did not feel she had the skills to move that initiative forward and did not know where to get that support.

As a result, and having noted my own frustration at the lack of progress being made on certain initiatives driven by our Parent Committee, I spoke to other parents on the committee and other parents whom I knew to have some interest in what we were doing through the Health School initiative, but were not directly involved. The comments were reiterated.

*I don't feel that I'm as productive as what I could be and that's probably part and parcel with part of my own insecurity being at home for nine years looking after kids, not out in the workforce, not dealing with people all the time so being able to put thoughts into action is not something that is being practiced on a daily basis. Um, I'm, you know, teaching the kids ABCs and 123s, so there's a level of insecurity on my part just as far as being able to maybe implement things.*

Parent, grades SK and 5 students

At the same time as I was doing my field work and learning about how some of the parents were feeling, a new parent (Maddie – a pseudonym) had just taken on the role of school council chair as well as volunteer coordinator, snack program coordinator and lunch supervisor. While advised against taking on so many roles by other school council members, she insisted she could do it. I provided some basic training regarding the snack program and the outgoing school council chair helped with the transition to that role. Maddie had no knowledge of how to chair a meeting and little support and guidance to acquire that knowledge. The school council, however, was grateful to have a chair. By Christmas, Maddie was overwhelmed and angry and quit every position, leaving three committees without leadership and one class of grade one children without a break and lunch supervisor. She agreed to return by mid-January to assume each role but returned with a very negative attitude and began to influence some of the parents who were also volunteering which caused significant turmoil within the school community, the effects of which are still being felt at the time of writing.

In observing the situation and reflecting on the personal attack on another friend and myself, I tried to analyze the situation in order to determine how, as a healthy school, we had left some key individuals feeling unsupported. Like some of the parents on the Parent Committee, Maddie had few skills, and few resources to help her attain those skills. Perhaps she was angry with me for not being there to offer the support she felt she needed. Unlike the parents on the committee, she handled her frustration in an unprofessional and destructive way. I wondered whether it was my role as the Healthy School Coordinator and a professional in the field, to provide skills for her and the volunteers. If it is not my role as a volunteer, it behooves us to find support somewhere in the community to assume that responsibility. Although culture is a dynamic concept influenced by many factors, it seems much easier to shift from a positive to a negative culture than the other way around.

Based on the four elements of CSH that Mohawk Gardens uses, social support is part of the comprehensive approach. Parents, as influencers and role models must be the recipients of education and skill building activities just as students and teachers are the recipients. Furthermore, the term social capital, which refers to positive characteristics of social organizations (a school) that help people work together in a coordinated and cooperative fashion, is paramount to positive health outcomes and academic achievement in schools (Sun & Stewart, 2007). Parents as part of this social organization must benefit from and contribute to the school's social capital including caring and supportive relationships, trust, and a sense of community.

A key strategy that facilitates collaborative school-community relations, caring relationships between school staff, student-teacher and student-

parents, is one that is characterised by the key elements of social capital such as trust, effective communication, and a collective action towards problem solving. However, few studies in published literature have examined the relationship between HPS and social capital, and the involvement of health promotion embedded in HPS model in building social capital at the primary school community settings. (Sun & Stewart, 2007, p. 557)

St Leger (2000) believes that it is the teachers who are vital to CSH, yet they do not have a clear understanding about the concept. He believes that in order to expand the health promoting schools concept and move it forward, more attention will need to focus on supporting teachers in ways that include understanding how they work and how their practice affects their ability to understand and embrace CSH.

While findings from the interviews suggest that teachers buy-in to health as a priority and support what we are doing at the school, there is still the feeling that it is an add-on as opposed to a foundation and they are not thinking about their own role in addressing social support, physical environments, or policy, but rather focusing on their role as health educator. St Leger (2000) makes the case that ministries of education and health must come together to provide professional development opportunities in order to facilitate that shift in thinking and practice. They must also recognize that in order for teachers to embrace this notion, it must be a balance between this being a top down versus a bottom up approach.



Miller (2003) highlighted a concern about the capacity of schools to implement and sustain health promotion programs when he indicated that many of the studies he reviewed identified educator training and participation as the problem. He argued, however, that educators have supported great numbers of health promotion programs over the years, until funding cuts and / or political change put an end to them and arrested the community development process that can take many years to build.

### *Resources*

Resources, such as funding, the physical environment (space) and time were also seen as both positive assets and challenges. From a physical environment perspective, the addition of walls has been seen as a positive improvement to the physical environment reported by interview participants. For as much as they are an improvement, other indoor and outdoor spaces were identified and described as prohibiting the school from supporting health promoting practices. For example, the school has one small gymnasium and it is often shared by two classes for physical education. If there is a public event (e.g., an election or school concert) the gymnasium cannot be used. Due to lack of lunch room supervisors, children in portables eat lunch and snacks in the gymnasium, leaving it unavailable for intramural sports and other activities. The YMCA operates an after school child care program, leaving the majority of children without access to the gymnasium after school. The gymnasium is completely inadequate for performances as there is no stage and not enough space to fit family and friends. The field is a big size featuring a creative playground, baseball diamonds and lots of space to run. The black top has physical activity markings as well as basketball nets. On wet days, however, the field does not have adequate drainage, thereby prohibiting the children from using it and

having to crowd onto the black top rendering them unable to run around and use many of the markings. While interview participants felt strongly about the need to address these issues, they acknowledge that these are extremely costly problems to fix.

Funding is a chronic issue facing schools with all of the priorities that need to be considered. However, according to Leurs, et al. (2006), a limited, yet growing number of studies world-wide have shown that school health promotion efforts are a positive and cost effective way to improve students' health so that they have the potential to benefit from school. At Mohawk Gardens, we have relied on grants, school council funding through fundraising, and donations to support our healthy school initiatives thus far, while the Principal has also provided funding to some of our endeavours (through some of his school funding). While some initiatives for which we have required money have been small in scale, some of the elements, for example changes to the physical environment, will require significant funding. Miller (2003) argued that schools have invested time and resources into health promotion programs but when human and financial resources are withdrawn, school budgets cannot support the creation and sustainability required with community partnerships.

A truly comprehensive model, one that involves community partnerships, could help to alleviate some of the resource and other capacity issues noted in this section. However, as St Leger (2000) notes, one of the barriers to advancing the CSH approach is "inadequate collaboration among the agencies whose expertise and resources are necessary to design and implement effective school health programmes" (p. 82).

*There has to be some political and some real system agreements in place to help us achieve Comprehensive School Health at a school level. When*

*barriers exist ... from a managerial system level, it really makes a difference to the lives of the children we service because they're the ones who aren't going to get use of space. They're the ones who aren't going to get services or programming – things we know they need to be healthy. So in terms of partnerships, are they legitimate? Or are they lip service? And that's the question ... In our community there is, to its credit, a movement recognizing the importance of partnership however they aren't community-wide and that's a real barrier to community groups such as Mohawk Gardens that has a very strong internal push for some healthy community action and capacity through a school to make things work where you don't have a lot of those pieces in other schools. And sometimes political alliances, who will get their money or who's liable become barriers and so the systems really need to be in place to help us working on the ground level up to actually make things come to fruition - environments that are supportive to the growth of our children and families.*

Public Health Nurse

I observed how our advocacy efforts to keep the school open have met with disinterest at best and dismissal at worst. On the other hand, a recent meeting that school members coordinated attracted 40 people including the city's Mayor, Regional Chair, Medical Officer of Health and City Councilor. The school received a great deal of support from many of the organizations who attended to work with school community members, including the same commitment from the regional chair. Members of the

Healthy School Steering Committee have since met with the city councilor who is helping to advocate on the school's behalf for a recreation centre in the community. Further, he emails Committee members to keep in touch and provide updates on what is happening city wide that pertains to the healthy school initiative.

Over seven years has been invested in establishing CSH at Mohawk Gardens, and I would argue, this is just the beginning. To the teachers, this gradual introduction has been one of the key features to the success of CSH. For parents, it has taken too long, precipitating the departure of at least one parent from school council and one of the original healthy school committees.

## CHAPTER 6

### REFLEXIVITY

Given my insider role to this research, it was important to bring my voice to the research. According to Patton (2002),

Reflexivity reminds the qualitative inquirer to be attentive to and conscious of the cultural, political, social, linguistic, and ideological origins of one's own perspective and voice as well as the perspective and voices of those one interviews and those to whom one reports. (p. 65)

Circumstances allowed me to conduct my research at Mohawk Gardens, which served not only to complete the requirements of my Master's degree but to fulfill a long standing wish, which was to tell our school's story. It is a story of which I am proud, in terms of both its triumphs and its challenges. Telling this story as an insider has been much more difficult than I anticipated. When I talk informally about what happens at the school, the words and thoughts flow easily. When I put all the events that have taken place and all the future initiatives being planned in the context of the literature pertaining to CSH, I am overwhelmed by the complexity of the approach. When I then consider the best practices with which I am familiar as a health promoter and consider them in light of the approach that we have taken – and that I have essentially led to introduce and build the CSH approach – I feel uncomfortable. I struggled with how to tell the story of how CSH came to be at Mohawk Gardens in a logical, coherent way because, in fact, its development was based more on happenstance and opportunities that presented themselves. One of the main learnings for me as a parent, then researcher, is that the

process of becoming a health promoting school is not a linear path. As this research concludes, and I return to my role of parent and professional, it has been a good lesson.

Throughout this research project, I attempted to continually reflect on my professional knowledge, the knowledge I had gained through the literature, the research process and my personal passion for CSH at Mohawk Gardens. Further, I was aware that school community members had different views of me from parent, community volunteer, and a leader at the school with respect to school health.

As an insider, I also felt a bit uncomfortable going into classes to observe and felt awkward being in the school without always being involved in the daily happenings. While I was familiar with all of the teachers and they were aware of my presence in the school, I was always worried that they would be uncomfortable having me in their classrooms. I wanted to ensure that I was both respecting our current and preserving our future relationship. I received different responses from school community members. The students were, for the most part, disinterested in my role, other than the friends of my own children. Most parents were very supportive of my work other than one who was openly critical. Teachers were interested and willing participants but admitted that when they saw me at the school, they were aware of the “health police” being in the building (interestingly they saw me as the health police irrespective of the role I was playing, which to me emphasizes the fact that we cannot separate the roles we play). One teacher avoided me every time he saw me coming!

I detected a shift in some people’s comfort level with me during interviews and when I was observing at the school from our regular interactions in the school yard or in the school. Participants often admitted to being nervous in the interviews. Some prefaced

their comments, or followed them up with some disclaimer related to not wanting to offend me or others involved with healthy school. Participants were very open about the challenges we faced in implementing CSH but cautious about being too negative. Occasionally, I was concerned that teachers and parents were answering questions based on what they thought I wanted to hear. I sensed they did not want to portray Mohawk Gardens in a negative way. I encouraged them to be open and honest in their responses so that this research could serve to advance the practice of CSH at both our school and others. Having said that, I enjoyed hearing the positive stories and felt uncomfortable and sometimes discouraged hearing the negative reactions or hearing of their disinterest and had to remind myself that all views are needed to guide the future direction and implementation of CSH.

I detected a shift in my own comfort level while at the school wearing my “research hat”. Hats are a funny thing. Researchers, irrespective of their study, wear several hats and they cannot be pulled off. Rather, the many hats we wear shape how we interpret our own world and shape how we attempt to interpret the worlds of our participants. I found myself, during interviews, jotting down how the words of those interviewed could be implemented at the school. I had to constantly focus on my job as the researcher, rather than the parent volunteer.

I kept a journal in order to record my feelings but did find it cumbersome and awkward given my lack of experience or interest in journaling in general. Most of the journal entries related to how things I saw and heard made me feel. For example, and I am not proud to say it, I felt that as someone who has championed the initiative, that credit for work that I had done was being assumed by others. It took me a while to step

back and realize how positive that was for the school from an internal leadership and ownership perspective and from a sustainability perspective.

As an insider, I continued to participate in a number of school activities during the three months in the field including attending three school council meetings, assisting with the dance-a-thon fund raising event, accompanying classes on field trips, chairing and healthy school meetings and implementing healthy school initiatives.

As I write and reflect on the activity that has taken place, on the energy and commitment that have helped maintain the enthusiasm, and on the achievements and set backs experienced, I am both impressed and dissatisfied when I think of the number of years that have been dedicated to this journey thus far. I am impressed with the significant gains that have been made in terms of the number of healthy school programs that are being offered, but worried about the threat of losing them due to our capacity to continue to deliver them. I am impressed with the earnest willingness to develop healthy school policy but discouraged when it comes to the willingness to put policy into practice or to address some of the contentious issues. I am impressed with the desire to know more about and strive toward building a health promoting school but disappointed by what I would describe as an inability to truly internalize the notion of health as a foundation of all aspects of child development as opposed to an add-on or the notion that being healthy is not “fun”. I am impressed with the many members of the school community that have supported the process but discontented with the lack of communications, awareness building and education that we have done to rally the remaining stakeholders.



We have accomplished a great many things in a long seven years, but have not moved forward on other aspects of building a health promoting school in those same very short seven years; meaning, seven years of work may seem like a long period of time to be working on some of the same issues, yet by community development and health promotion standards is acceptable and recognized as only the start of a long and steady journey. The policy that was developed five years ago is still awaiting revisions. Perhaps once completed, the policy directives with their rationale may be better communicated to all members of the school community, with a better chance for understanding and adoption. Strategic planning appears on almost every agenda of the Healthy School Steering Committee but given the time commitment required to adequately develop it, it has only been tackled in a preliminary way. There have been successes and set backs, celebrations and discontent. It is the reality of working in a system that is composed of many juxtapositions: volunteers and paid staff; bureaucracy and the desire to be unburdened by such a system; personal values, beliefs, and interests that are based on an expanded view of the school as a community hub versus its role as an academic institution; the perceived roles of parents and teachers in the development of children. These are the issues reflected in this school's story – my story and my account of this school's story!

## CHAPTER 7

### CONCLUSIONS AND RECOMMENDATIONS

The purpose of this research was to describe the characteristics of one school's Comprehensive School Health initiative and to explore the experiences of school community members in order to gain an understanding of how one school embraced the Comprehensive School Health approach. In this case, Mohawk Gardens Public School, has indeed focused a great deal of its time on many of the program and curricular elements but has also endeavoured to address some of the social, physical and policy supports inherent to a Comprehensive School Health model (CASH, 2006). When interview participants were asked what their vision was of a healthy school and how it related to Mohawk Gardens, they described Comprehensive School Health as addressing physical activity and healthy eating, but in most cases looked more broadly at the importance of additional topics to be addressed, such as respect/bullying and the physical environment. Furthermore, they spoke, to some extent, about the many layers to Comprehensive School Health – the role of parents, the impact of the community, the complexity of reaching all members of the school community, the time that was required to build and embrace a Comprehensive School Health model, and its integration into the fabric and culture of the school.

I explored what school community members felt the impetus was to engage in Comprehensive School Health. My role as the champion and the Principal's role as a leader to build and sustain the approach were highlighted. The fact that I had some knowledge and skills in health promotion was seen as an asset and necessary resource in building CSH. According to Freudenberg, et al. (1995), to be effective, health promotion

interventions must build on the strengths found among the participants and build upon them to strengthen their communities.

In exploring how CSH was practiced, participants generally recognized the importance of a broader health promotion strategy than simply the curriculum and program components which are consistent with the findings of Freudenberg, et al. (1995) who argued that “effective interventions integrate efforts aimed at changing individuals, social and physical environments, communities and policies” (p. 297). This is further illustrated in the literature that suggests the key strategies for Comprehensive School Health are instruction, social support, supportive physical environments and a link to the community are the cornerstones of CSH (CASH, 2006, Stewart-Brown, 2006, WHO, 2002, Moon, et al., 1999).

While my goal was not to evaluate whether or not the approach improved health indicators, the purpose was to explore what issues and features characterized a health promoting school. In analyzing the interview, documents and observational data, three major themes emerged that characterized this school’s experience: The first theme, “Understanding the concept of CSH” was my interpretation of what seemed to be a struggle to reconcile the definition of health and the vision of a healthy school with what that really meant to the participants, how those terms were understood in the context of the daily business of the school and how the different relationships of school community members supported health. McLeroy, et al. (1988) suggest that integrating individual health promotion strategies with strategies aimed at supporting intrapersonal and environmental supports are critical to changing behaviour, yet a tension remained between these levels. Further, seeing health as an “add-on”, often described as

“competing priorities” was identified as a challenge which I interpreted as a barrier to true understanding of the concept.

The second theme, “Capacity” was a very strong theme, broad in its definition. It emerged through observations and participant records that related to both successes and challenges and what participants believed were the key ingredients to a Comprehensive School Health approach. Participants identified the “key ingredients” that they believed were central to a health promoting school. Physical, financial, skills and knowledge and social capital were aspects related to capacity and supported by the literature (Stewart-Brown, 2006, Freudenberg, et al, 1995, Moon, et al, 1999). While all were significant, skills and knowledge and social capital were the most significant for the Mohawk Gardens experience from both a positive and negative perspective. Volunteers overall were mentioned as important but teachers, parents and community members mentioned the need for a champion and one with health promotion knowledge and skills. My involvement specifically came up as a parent leader who had passion, interest and knowledge. Therefore, while the school was deemed to have leadership with skills and knowledge to support the initiative, building and sustaining that capital was an issue. Sun and Stewart (2007) found that a health promoting school approach was effective for building social capital, and was comprised of a “strong multidisciplinary and collaborative partnership between health and education organizations, a constant communication between staff, parents and students within intervention schools, and participation and engagement of staff, students and engagement of staff, student and parents” (p. 568).

Teachers commented about how it enhanced their own professional development in the area of health and health promotion, making the experience even more valuable and increasing their commitment. According to St Leger (2000) “the health-promoting school framework requires teachers to work together to shape and implement its building blocks. This is supported by comprehensive literature which suggests that collaboration is a fundamental requirement to developing health-promoting schools” (p. 84).

Finally, “Positive School Culture” emerged as the third theme with aspects identified that are consistent with Goldring’s (2002) findings identifying a number of characteristics that contribute to culture including a shared vision, traditions, collaboration, shared decision-making, innovation and communication. Not all of these criteria were present based on the different methods of data collection, however the process was in place and all aspects were being addressed. Other aspects including ownership, traditions, role-modeling, and stakeholder buy-in were evident through both participant interviews and observations, particularly related to the physical environment.

### *Research Considerations*

A great many lessons were learned in conducting the study but it is important to separate my parent volunteer role from my researcher role. As a parent, my inclination is to discuss what we as a school should have or could have done differently to move the CSH agenda forward and what we will do as a result of the learnings from this research.

As a researcher, the lessons learned address the research process itself. First and foremost, I would have spent far more time in the field doing observations as my hesitancy to be in the classrooms, and areas such as the staff room, reduced the amount of

rich descriptive data that might have been possible. Time in the field would also have consisted of spending “a day in the life” of the administrators, support staff and teachers. Time did not allow for this to happen, however, I feel it would have provided critical insights to how and why people in the school understand the concept of CSH the way they do.

Interviewing children proved to be the most challenging aspect of this research. I anticipated that they would be open and forthcoming. Instead, other than the two older students in grades 5 and 6, they were nervous and quiet. I tried asking the questions using simple words and short questions. Their attention spans were short and they were distracted when they heard other children running around (all but one interview with students took place in a room off of the library with the door open most of the way). I actually found it frustrating but am fully aware that it is due to my inexperience that the interviews were less fruitful than they could have been. Next time, I would practice a series of interviews with children of different ages. Another approach to evoke responses would be to ask the children to draw pictures and then tell me about the picture or aspects of the picture that related to my question.

The children have less of a voice in this research despite the fact that the main focus of CSH is focused on children. To date, the Mohawk Gardens healthy school initiative itself has been more focused on doing “for” and “to” the children rather than “with” their input, a main premise of health promotion. I spent much time observing the children, however, I tended not to report these observations which I believe is due to the fact that my familiarity with the school setting may have caused me to take for granted what I was seeing in terms of their behaviour and involvement related to CSH.

Future research would involve additional case studies in the area of CSH, both single case studies and those using multiple sites. While the intent was not to generalize the findings, but rather to understand how one school embraced CSH, the findings from additional schools would help to provide credence to some of the recommendations provided below. Future studies must also look at CSH, using the socio-ecological model in its entirety from an evaluation perspective. Future case study research of health promoting schools might consider a comparison study between schools with different levels of support to determine whether or not the experiences are similar, for example schools that have a dedicated resource person, as with the Living Schools model from OPHEA.

Finally, action research studies would not only serve to learn about how schools operate in the context of Comprehensive School Health but would facilitate an opportunity to move this concept forward in a way that engages all aspects of the model.

### *Recommendations*

In determining the recommendations, I considered the literature and the research findings. I also thought about how parents and teachers might think about how to move this initiative forward. To do this, I wondered how an individual can distinguish between what factors we can change or influence and what we cannot. Do members of a school community believe that they have the ability, right, and capacity to change or influence these changes, particularly if they hold the belief that the education system has one singular and distinct purpose, with health being the parents' responsibility? Taken together, I would make the following recommendations, presented using the levels of

influence identified in the socio-ecological model as a framework, to increase the number of schools engaging in Comprehensive School Health and to support schools already engaged.

*Individual.* In order to support teaching and learning approaches that focus on raising awareness and skill building for children, I recommend that provincial governments reinstate Physical and Health Education Specialists at the elementary school level. In so doing, I believe that Physical Education, Kinesiology and Community Health degrees should have health promotion curricula (theory and practical opportunities) as a required part of the curriculum. While health promotion courses should be integral to those specific degree programs, Education degrees should also receive some health promotion education.

*Interpersonal.* Parents and caregivers should be included in every health promotion initiative that takes place in relation to the school. Given their influence and overall responsibility for health, parents must also be made aware of not only what their child is doing and learning, but must have the knowledge and skills to support their child. This can happen in many different ways from communications to participation in initiatives at home or at the school. Every school function should include healthy lifestyle messages and activities.

*Institutional/Organizational.* As a foundation, CSH provides the basis upon which decisions are made at the school. It is related to a philosophy in that members of the broad school community value health, believe that a child needs to be healthy in order to thrive academically, physically, socially and emotionally, and hold the belief that the school has an important role to play. Health, then, is one foundational concept, and CSH



is an approach that provides the foundation upon which to support health by addressing the complex and multi-dimensional determinants that affect health.

As the “gatekeeper”, Principals have the ability to act as a major facilitator and champion for CSH but could just as easily forbid the school from engaging in CSH. After seven years of building our CSH approach, how could a new Principal be allowed to dismantle or not support the work that has been done to date and the plans made for the future? Yet this is the reality of what can and does happen. Therefore, Principals should also participate in training related to CSH and health promotion in general. They should be required to abide by the direction that a school is currently undertaking in the area of CSH. If the initiative is not already underway but is being introduced, Principals should be required to ensure that ideas (not just related to CSH) are appropriately vetted through school councils.

Boards of Education should hire Healthy School Coordinators for a certain number of schools in their Board. Each Coordinator would ideally have a health/health promotion background or have received the appropriate training. Coordinators would provide support to schools in the form of advice, teacher and parent skill development and training, and other support as required. They would also play a seminal role as liaison with community partners and at the local and national level.

What may even further strengthen capacity within the school is to provide education and training to parents from the perspective of health promotion. Parents, as leaders, should be provided with educational and skill building opportunities as it is their role as insiders that may provide more of the impetus to sustain Comprehensive School Health.

A family of schools should work together in order to ensure that there is a seamless transition as children graduate from one school and move to another. Schools should develop joint school health strategies with the assistance of the School Health Coordinator. In the absence of this position, the Physical and Health Curriculum consultant could assume this role having received appropriate training in health promotion.

Schools should consider the cultural and ethnic demographic and understand how their culture defines health, and how they view the school in general. Cultural training might be determined to be mandatory for all staff and school health committee members.

Finally, all schools should be required to have a Healthy School committee, with dedicated time allocated for meetings at time convenient to all committee members. Committees should consist of teachers, administration, parents and community partners. Students must be involved in some way (not likely on the same committee but in a way where their feedback and input is obtained and acted upon). Each school should develop a healthy school policy or adapt a board-wide policy. Healthy school policy goes beyond safety and includes health promotion.

*Community.* Communities should be developing health promotion strategies that include schools as one of the institutions within a community where healthy practices are enabled. One way to do this is to begin to build (with bricks and mortar or philosophically) schools as the “hub” of the community. They become gathering places where daycares and preschools exist, older adults gather to socialize with each other and with the students, classes take place and recreational opportunities are offered. Further, families can receive some health care services there as well (e.g., clinics, flu shots,

receive health information). The library would be open to everyone and meeting rooms would encourage citizens to come together to discuss issues related to their communities and meet with local politicians and decision makers.

Community organizations must do a better job of working together in a meaningful way. Tax-payer funded organizations should be working together to offer services that enhance health. For example, swimming and skating lessons should be free of charge and community members should have access to school facilities after school hours free of charge. If recreation centres do not exist in an area of a community, schools should be opened and used as a recreation facility.

*Public Policy.* Schools reside in neighbourhoods and as such, neighbourhoods and communities should be designed to support active and environmentally friendly transportation to and from schools. Some options include reassessing the distance from homes to schools to qualify for bussing. Buses should be available at different times in order that students can remain at school and participate in activities. Every neighbourhood with a school should participate in a walking audit to determine its walkability.

In 1950, an Expert Committee on School Health Services, established by the WHO, produced a report calling for, among other things, a more comprehensive approach to curriculum programs in health and pre-service training for teachers in the area of health. A second report in 1954 provided a significant change in thinking by suggesting that the school and non-school sectors in health education should both train together and work together. This is an idea that must be pursued. University students in Faculties of Education would benefit from health promotion curricula while those

studying health and health promotion must become better versed in the school setting and the demands of that setting. Integrating the disciplines may provide a better chance of fully integrating health as a foundation in every school setting.

A certain percentage of taxes collected and funding that goes to hospitals, and other publicly-funded health institutions should be put toward supporting health promotion at the school and community levels as well as to recreation services in communities. To further build on that, the school should be seen as a hub of the community, a place where services are integrated in order to meet the needs of children, parents, extended family, teachers and community members.

*The link between a child's health and education is a powerful one ... 'school health programmes that coordinate the delivery of education and health services and promote a healthy environment could become one of the most efficient means available for almost every nation in the world to improve significantly the well-being of its people. Consequently, such programmes could become a critical means of improving the condition of humankind globally'. (WHO, as cited in Moon et al (1999), p. 112)*

A final goal would be that health promotion is part of a seamless strategy that is integrated into every aspect of our lives from birth to death. In the absence of that, Comprehensive School Health offers a unique opportunity to engage our most vulnerable population in health promoting behaviours. Because of their universality, schools, through CSH have the potential to reach all children through highly trained individuals in the school and in the community.

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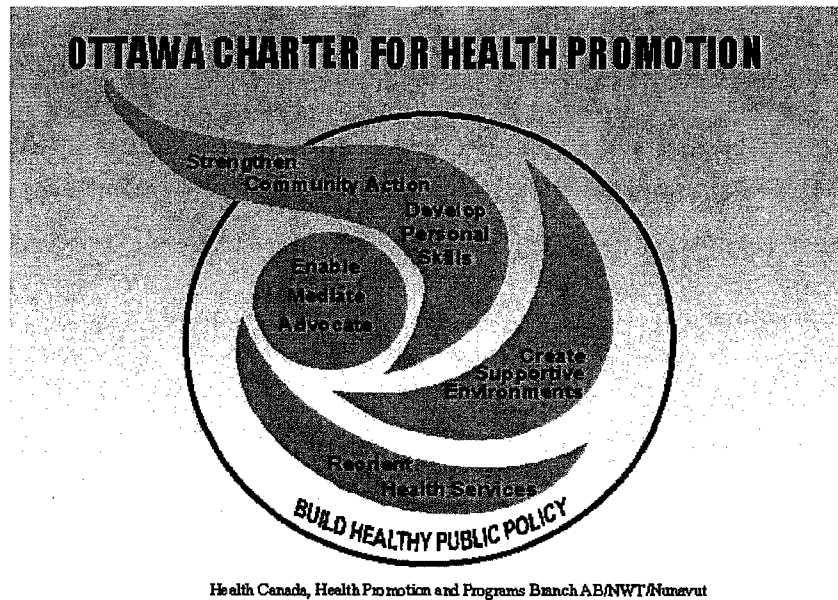
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Appendix A  
The Ottawa Charter for Health Promotion  
World Health Organization, 1986



The following are the definitions as provided in The Ottawa Charter

### **Responsibilities / Skills of Health Promoters**

#### *Advocate*

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

#### *Enable*

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.



*Mediate*

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health. Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

**Health Promotion Strategies***Build Healthy Public Policy*

Health promotion puts health on the agenda of policy makers in all sectors and at all levels. The goal is to prompt them to take responsibility of the role they can play to improve health. Health promotion policy comprises legislation, fiscal measures, taxation and organizational change. It is coordinated action that takes into account the social determinants of health. Health promotion policy identifies barriers that organizations may face in adopting healthy public policies and provides solutions to remove them.

*Create Supportive Environments*

Health is linked to every other aspect of our lives. We must adapt a socioecological approach to health. As a global community, we need to take care of each other and the environment. Health promotion creates living and working conditions that are safe, stimulating, satisfying and enjoyable. We must continue to assess the health impacts of a rapidly changing environment.

*Strengthen Community Actions*

Health promotion works by empowering communities to set priorities, make decisions, and plan and implement strategies to achieve better health. Community development relies on human and material resources in the community to increase public participation in health.

*Develop Personal Skills*

Health promotion, facilitated in school, home, work and community settings, supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

*Reorient Health Services*

The responsibility for health promotion is shared among individuals, community groups, health professionals, health service institutions and governments. They must work

together towards a health care system which contributes to the pursuit of health. The role of the health sector must move beyond providing clinical and curative services, and in a health promotion direction. Reorienting health services also requires more focus on health research and changes in professional education and training.

## Appendix B

### Canadian Consensus Statement (Revised 2007) Schools and communities, working in partnership to create and foster health-promoting schools

#### COMPREHENSIVE SCHOOL HEALTH

*This Consensus Statement has been prepared and endorsed by a number of national organizations to promote a comprehensive approach to school-based and school-linked health promotion. This comprehensive approach integrates responses to several health and social problems and promotes the overall health and learning of children and youth, as well as adults who work in and with schools, parents/caregivers and surrounding communities. This approach also seeks to coordinate multiple interventions in the form of policies, programs and services delivered by various professionals, agencies and government ministries.*

#### **The Issue**

The health and well-being of children, youth and school personnel is influenced by many factors, including family income, social support networks, personal health practices and coping methods, biology and genetics, education, and the physical environment of the home and school (1).

It is also clear that health promotion in schools can improve children's health and well-being (2, 3). Comprehensive School Health, also known as "health promoting schools" in some regions, refers to a multifaceted approach that includes teaching health knowledge and skills in the classroom, creating health-enabling social and physical environments and facilitating links with parents, local agencies and the wider community to support optimal health and learning (2, 4). Experience and research indicate that, while results vary between programs, such a comprehensive approach to school health promotion can influence the health-related knowledge, attitudes and behaviours of students, and alleviate factors that compromise health (2). There is also a growing recognition of the relationship between health and academic performance (5).

Expectations of the school setting for health improvement must be realistic, as the social determinants of health as well as family expectations and practices, have a profound impact on health. However, supportive school environments that foster resilience and focus on asset development, protective factors and social connectedness, reduce the risk of health-related problems and support the healthy growth and development of children and youth.

#### **The Goals**

The goals for a health promoting school, adapted from those prepared by the World Health Organization (6), are to:

- Foster health and learning with all the measures at its disposal;

- Engage health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place for all;
- Strive to provide a healthy environment, school health education and school health services, health promotion programs for staff, healthy food choices, daily physical activity/education, and programs for counselling, psychological intervention, social support and mental health promotion;
- Implement policies and practices that respect an individual's well-being and dignity, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements.

### **The Components**

A comprehensive approach to school-based health promotion is designed, not only to affect individual health behaviours, but to also provide supportive environments in which young people live and learn. Comprehensive school health calls for an integrated approach that incorporates health and health messaging into all aspects of school activities and engages the community at large. It incorporates four main elements – teaching and learning, health and other support services, supportive social environment and a healthy physical environment (6):

1. Teaching and learning - is the basic way students and staffs receive information about health, wellness, health risks and health issues (4). It includes:

- a comprehensive, K-12 health curriculum encompassing all facets of health (mental, physical, emotional and spiritual), varied materials and media; cross-curricular learning opportunities, incorporation of learning strategies that are culturally sensitive and developmentally appropriate; and lifestyle-focused physical education;
- effective teaching and learning approaches that support development of students' knowledge, attitudes, skills and behaviours for healthy decision making; fosters life skills such as health literacy, problem-solving, communications skills and promotes a sense of personal competency, self-efficacy and social responsibility;
- the planned use of other informal learning opportunities;
- effective pre-service and in-service training for educators.

2. Health and Other Support Services – the availability and accessibility of health and other support services are keys to the early identification and treatment of many problems that can lead to long-term learning difficulties if not addressed (4). Many of these services are appropriately delivered through the school. Others should be delivered through public health, social service organizations, government/non-government agencies and other local agencies and community partners. For children and families, the school is often the most important access point for students and families. Examples of such services include:

- social and psychological screening/assessments for early identification, intervention and referral where appropriate;
- child protection and other social work services;
- public health services;
- guidance services, psychological intervention and mental health promotion;

- services for special needs students;
- treatment, post-treatment support and rehabilitation services;
- police services;
- recreational services;
- after school programming
- pre-service and in-service training of health and other professionals;
- active coordination of services and programs.

3. Supportive Social Environment – refers to the mental health and social support available within the school and in relation to the home and community. It may be informal (i.e. friends, peers, teachers) or formally articulated through school policies (4).

Examples include:

- role modeling by school staff and others;
- peer support and support group development;
- community participation and media cooperation;
- staff wellness programs;
- appropriate school discipline policies and effective management practices;
- active student and parent participation.

4. Healthy Physical Environment – a clean, safe, health-promoting environment helps prevent injuries and disease; it also enables healthier choices (4). Examples include:

- safety procedures and regulations;
- sanitation, clean water and hygiene standards;
- environmental health standards;
- food and nutrition policies that promote healthy eating including access to healthy foods as well as safe and supportive eating environments;
- smoke-free school policies;
- multiple opportunities for physical activity including sport and extra-curricular activities
- accessible and sustainable environments that promote physical activity, safety and freedom from bullying or harassment.

### **The Partners**

The programs, activities and services delivered within such comprehensive approaches to school health are the responsibility of everyone in the community: young people; families; professionals, institutions, agencies and organizations concerned with children and youth; the education, health, social services, law enforcement, and voluntary sectors; the broader community and governments at all levels. Each of these individuals, organizations and government departments can potentially contribute to teaching and learning, health and other support services, supportive social environments and healthy physical environments. Effective linkages between partners and coordination at all levels, from national to local school levels, are fundamental to sustainability.

### **The Organizational Capacities**

In order to support health-promoting school communities in a sustained manner, the organizational capacities of health and education systems (ministries, agencies, schools, professionals, communities) need to be strengthened in areas such as (7, 8):

- comprehensive and coordinated policies on school health, health issues and the elements of school health promotion that are actively supported by senior managers;
- assigned staffing infrastructure to support interdisciplinary cooperation at all levels;
- formal and informal mechanisms for coordination and cooperation;
- active knowledge transfer and exchange within and across sectors;
- ongoing workforce development of health and education professionals through professional preparation programs and staff development;
- providing regular and reliable data on the health status, determinants, behaviours, attitudes, skills and knowledge of children and youth, as well as periodic surveys and self-assessments of policy/program capacity;
- regular scans of the environments, trends and emerging issues that affect the health of children and youth;
- appropriate and sustained funding to ensure the continuance of programs which demonstrate effectiveness.

### **The Benefits**

An authoritative systematic review of the literature on the effectiveness of the health promoting schools approach concluded that, while there is wide variability among programs, school health promotion can improve the health and well-being of children and youth. Initiatives most likely to be effective are those that use a multifaceted approach that includes classroom instruction, change in the social and physical environment of the school, creation of links with the wider community and are sustained over a long period of time. There is a need for further research on promoting health in schools to more clearly establish what works, why it works, and its cost effectiveness (2).

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[http://www.who.int/school\\_youth\\_health/media/en/454.pdf](http://www.who.int/school_youth_health/media/en/454.pdf)

The following organizations have endorsed the statement on Comprehensive School Health (others to be listed as permission is received).

Boys and Girls Clubs of Canada

Breakfast for Learning

Canadian Alliance of Community Health Centre Associations

Canadian Association of Chiefs of Police

Canadian Association of Health, Physical Education, Recreation and Dance

Canadian Association for School Health

Canadian Centre for Ethics in Sport

Canadian Association of School Administrators

Canadian Association of Student Activity Advisors

Canadian Centre on Substance Abuse

Canadian Child Care Federation

Canadian Council for Tobacco Control

Canadian Counselling Association

Canadian Federation for Sexual Health

Canadian Home and School Federation

Canadian Mental Health Association

Canadian Nurses Association

Canadian Paediatric Society

Canadian Parks and Recreation Association

Canadian Psychological Association

Canadian Public Health Association

Canadian Red Cross

Canadian Safe School Network

Canadian Teachers' Federation

Chronic Disease Prevention Alliance of Canada

Community Health Nurses Association of

Concerned Children's Advertisers

Dietitians of Canada

Heart and Stroke Foundation of Canada

Métis National Council

School Health Research Network

Sex Information and Education Council of Canada (SIECCAN)  
Society of Obstetricians & Gynaecologists of Canada  
St. John Ambulance  
The Centre of Excellence for Youth Engagement  
Thrive! The Canadian Centre for Positive Youth Development

For further information on Comprehensive School Health, contact:

Canadian Association for School Health  
16629 – 62A Avenue, Surrey, BC, V3S 9L5  
info@cash-cces.ca  
604 575 3199 4

Or visit the web site: **[www.safehealthyschools.org](http://www.safehealthyschools.org)**



## Appendix C

### Sensitizing Concepts

#### Ottawa Charter for Health Promotion (The Ottawa Charter)

The Charter, created in 1986 and released at the First International Conference on Health Promotion, is made up of three responsibilities of health promoters and five strategies. The three skills are Enable, Mediate and Advocate. The five strategies that should be employed in order to improve health are Create Supportive Environments, Develop Personal Skills, Reorient Health Services, Build Healthy Public Policy and Strengthen Community Action.

#### Health Promotion

According to the World Health Organization, the definition of health promotion is

the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. (Oxford Press, 1987, pg. 1)

## Canadian Consensus for Comprehensive School Health: The Four Elements of a CSH

Approach (See Appendix B for the Statement in its entirety).

The Consensus Statement incorporates four main elements<sup>3</sup>.

▪ **Teaching and Learning (Instruction):** described as the way in which teachers and student receive health information. The types of approaches included in this element include a comprehensive health curriculum from Kindergarten to grade 12, effective teaching and learning approaches, the use of informal learning opportunities, and pre-service and in-service training for educators.

▪ **Health and Other Support Services (Preventive Health Services):** that assist with the identification and treatment of a number of health- and education-related problems. Whether or not the school provides these services, or they are offered through community partners (public health units, recreation services, child protection, guidance counseling), the school becomes the point of access.

▪ **Supportive Social Environments (Social Support):** describes the informal (friends, peers, teachers) and formal (programs and policies) social support available within the school and encompassing the home and community. Examples such as role modeling by school staff, peer support, staff and parent programs, contribute to the mental health and social well-being of members of the school community.

▪ **Healthy Physical Environment** ensures that not only are safety and hygiene standards met, but that the school environment supports healthy, active choices.

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<sup>3</sup> Since the original writing of this paper, Teaching and Learning is now referred to as *Instruction*, Health and Other Support Services is known as *Preventive Health Services* and Supportive Social Services is called *Social Support* (<http://www.cash-aces.ca/index.asp?Page=Consensus>).

Appendix D  
Recruitment Materials

**Letter of Invitation [printed on Brock U. letterhead]**

[date]

Mr. A.K.  
Principal, Mohawk Gardens Public School  
5280 Spruce Ave., Burlington ON L7L 1N3

Dear Mr. K.,

**Title of Study:** Descriptive Analysis of a Health Promoting School: A Case Study  
**Principal Investigator:** Christa Costas-Bradstreet, Master of Arts Student, Faculty of Applied Health Sciences, Brock University  
**Faculty Supervisor:** Dr. Nancy Francis, Faculty of Applied Health Sciences, Brock University

I, Christa Costas-Bradstreet, Master of Arts Student, from the Faculty of Applied Health Sciences at Brock University invite you to participate in a research project titled *Descriptive Analysis of a Health Promoting School: A Case Study*. The purpose of this research is to describe and analyze the characteristics of an established health promoting school.

As a school involved in Comprehensive School Health, members of your school community are in a unique position to share their experience with this health promotion strategy. I would like to invite you to share this expertise by participating in this case study, expected to take place between October 2007 and January 2008. I would like to collect information in three different ways. First, I would like to examine public documents such as healthy school meeting minutes, policy documents, parent newsletters, etc. Second, I will be conducting observations of the school environment. For example I would observe the physical surroundings inside and outside of the school (posters, whether sidewalks are available, if there are bike racks, etc. related to your healthy school approach). Third, I would like to conduct interviews with parents, teachers, students and community members involved with the Comprehensive School Health initiative, such as your Public Health Nurse or Parks and Recreation partner.

The name of your school will not be used in reports generated as a result of this research, (unless you deem it appropriate), nor will individual names be used. Interviews will be assigned a code based on whether the interviewee is a student, teacher, parent or community member. Initials will be used only for the interviewer's information in order to check the interview notes with the interviewee. Once the interview notes have been approved by the interviewee, the initials will be removed from the transcript.

- 2 -

It is my hope that this research will benefit your school community (students, parents, teachers and staff), the Halton Region School Board and other school boards, as well as people who work in the health field. It is the only school involved in this particular research project. As a token of appreciation for your participation, I would like to provide some physical activity equipment for the children to use during their recess and lunch breaks.

If you have any questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905 688-5550 ext 3035, [reb@brocku.ca](mailto:reb@brocku.ca))

If you have any questions, please feel free to contact me directly or my advisor.

Thank you,

Christa Costas-Bradstreet  
MA Student, Brock University  
(905) 639-4193  
[cc89hc@brocku.ca](mailto:cc89hc@brocku.ca)

Dr. Nancy Francis  
Associate Professor, Brock University  
905-688-5550 ext. 4366  
[nancy.francis@brocku.ca](mailto:nancy.francis@brocku.ca)

**This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board (file # 06-297)**

Appendix E  
Consent Materials  
Letter and Consent Form #1 (template: HDSB)

Dear Parents:

I am a graduate student in the Faculty of Applied Health Sciences at Brock University and I am conducting a study that describes how your child's school promotes health to the students, teachers, parents and community members and to learn about the healthy changes that the people who are part of your school have made. I would like to include your child in the study.

Sometime in October or November, I would like to sit down with your child and ask him or her to answer some questions about how he/she learns about healthy lifestyles while at school. I will ask them about topics such as physical activity, healthy eating, and the physical environment of the school (inside and outside). I will also ask them about some of the activities that they participate in that help them to learn about these topics. If your child is in grades JK to two, I may ask them to draw a picture for me of what their healthy school looks like.

Your child's responses will not be identified by name and I will not use information from school records. The Halton District School Board's Research Advisory Committee and subsequently your child's school Principal have officially approved this study. When the study is completed, a report on the findings will be available in the school library for interested parents.

Please complete the form at the bottom of this letter and return it to your child's teacher by September 20<sup>th</sup>, 2007. If, on the research day your child is unwilling or unable to participate, his/her feelings will be respected.

I sincerely appreciate your co-operation. If you would like to receive more information about the study, please contact me or my faculty supervisor at [costasbradstreet@cogeco.ca](mailto:costasbradstreet@cogeco.ca) or at 905-688-5550 ext. 4366.

Thank you,  
Christa Costas-Bradstreet  
Graduate Student  
Faculty of Applied Health Sciences  
Brock University

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Child's Name \_\_\_\_\_

Indicate your choice by checking the appropriate box:

- ☐ I give my child permission to participate in Brock University's study conducted by Christa Costas-Bradstreet
- ☐ I do NOT give my child permission to participate in Brock University's study conducted by Christa Costas-Bradstreet

Signature of parent/guardian \_\_\_\_\_

**PLEASE RETURN TO YOUR CHILD'S TEACHER BY DATE**

Appendix E  
Consent Materials  
Final Letter and Consent Form #2 (template: HDSB)

Dear Parents:

I am a graduate student in the Faculty of Applied Health Sciences at Brock University and I am conducting a study that describes how your child's school promotes health to the students, teachers, parents and community members and to learn about the healthy changes that the people who are part of your school have made. I would like to include your child in the study.

During the months of September to December of this year, I will be in the school talking to students, teachers, staff and parents about their healthy school. While I will be conducting formal interviews, which your child may be asked to participate in, I may also have an opportunity to chat informally with some of the students while I am at the school. I would be asking them some questions about how they learn about healthy lifestyles while at school, and about topics such as physical activity and healthy eating. I would also be asking them about some of the activities that they participate in that help them to learn about these topics. If your child is in grades JK to two, I may ask them to draw a picture for me of what their healthy school looks like.

Your child's responses will not be identified by name and I will not use information from school records. The Halton District School Board's Research Advisory Committee and subsequently your child's school Principal have officially approved this study. When the study is completed, a report on the findings will be available in the school library for interested parents.

If you do NOT want me to speak to your child about their experience at the school, please complete the form at the bottom of this letter and return it to your child's teacher by September 20<sup>th</sup>, 2007. If you DO indicate that I may speak to your child, but your child is unwilling to participate, his/her feelings will be respected.

I sincerely appreciate your co-operation. If you would like more information about the study, please contact me at [costasbradstreet@cogeco.ca](mailto:costasbradstreet@cogeco.ca) or Dr. Francis at 905-688-5550 ext. 4366.

Thank you,  
Christa Costas-Bradstreet, Graduate Student  
Faculty of Applied Health Sciences, Brock University

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Child's Name \_\_\_\_\_

Indicate your choice by checking the appropriate box:

- ☐ I give my child permission to participate in Brock University's study conducted by Christa Costas-Bradstreet
- ☐ I do NOT give my child permission to participate in Brock University's study conducted by Christa Costas-Bradstreet

Signature of parent/guardian \_\_\_\_\_

**PLEASE RETURN TO YOUR CHILD'S TEACHER BY DATE**

## Appendix E

### Consent Materials

#### Informed Consent Template

Date: September, 6<sup>th</sup>, 2007

Project Title: Characteristics and Descriptive Analysis of a Health Promoting School: A Case Study

Principal Investigator:  
Christa Costas-Bradstreet, Master of Arts Student,  
Faculty of Applied Health Sciences, Health and Physical  
Education, Brock University  
905-639-4193  
costasbradstreet@cogeco.ca

Faculty Supervisor (if applicable):  
Dr. Nancy Francis, Faculty of Applied Health  
Sciences, Health and Physical Education, Brock  
University  
(905) 688-5550 Ext. 4366  
Nancy.francis@brocku.ca

#### *INVITATION*

You are invited to participate in a study that involves research. The purpose of this study is to describe how your child's school promotes health to the students, teachers, parents and community members and to learn about any changes that have been made as a result. This is the only school participating in this current study.

#### *WHAT'S INVOLVED*

As a participant, you will be asked to meet with the researcher and answer approximately 15 questions. The purpose of the research will be explained at the beginning of the interview and you will be asked to sign a consent form if you have not already done so. The interview will be taped for the researcher's purposes only. Participation will take approximately 45 to 60 minutes of your time.

#### *POTENTIAL BENEFITS AND RISKS*

Possible benefits of participation include information that may benefit your school and other schools as they strive to implement healthy school initiatives. It is also hoped that the information will help health promotion professionals working with and in schools to serve their health promotion needs. Ultimately, we are hoping to find out more about how we can improve the health of our children, parents, teachers and community members. There are no known or anticipated risks associated with participation in this study.

#### *CONFIDENTIALITY*

The information you provide will be kept confidential. Your name will not appear in any thesis or report resulting from this study; however, with your permission, anonymous quotations may be used. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. Information collected during this study will be locked in a filing cabinet at Brock University as well as stored on a separate computer disk. Data will be kept for approximately two years after which time the written documents will be shredded. Access to this data will be restricted to Christa Costas-Bradstreet (Principal investigator) and members of the

study committee, all professors at Brock University (Drs. Francis, Kikulis, Lodewyk, and Breunig).

### *VOLUNTARY PARTICIPATION*

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits to which you are entitled.

### *PUBLICATION OF RESULTS*

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available to your school Principal in the fall of 2008.

### *CONTACT INFORMATION AND ETHICS CLEARANCE*

If you have any questions about this study or require further information, please contact the Principal Investigator or the Faculty Supervisor (where applicable) using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University (file # 06-297). If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

### *CONSENT FORM*

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Appendix F

### Interview schedule

<b>Interviews</b>				
<b>Name</b>	<b>Invited</b>	<b>Accepted</b>	<b>Date Scheduled</b>	<b>Location</b>
<b>Teachers</b>				
Teacher A (Library/PE)	✓	✓	Dec. 4 <sup>th</sup> at 10:30 a.m.	Researcher's home
Teacher B (Kindergarten)	✓	✓	Nov. 14 <sup>th</sup> at 7:30 p.m.	Participant's home
Teacher C (Grade 1)	✓	✓	Dec. 4 <sup>th</sup> at 2:45 p.m.	Participant's classroom
Teacher D (Grade 2)	✓	✓	Jan. 14 <sup>th</sup> - 1:00-1:40	Snack room
Teacher E (Grade 3)	✓	✓	January 8 <sup>th</sup> /08 at 3:30	Participant's classroom
Teacher F (Grade 5)	✓	✓	Nov. 28 <sup>th</sup> at 7:50 a.m.	Participant's classroom
Teacher G (Grade 4/5)	✓	✓	Dec. 11 <sup>th</sup> at 3:30 p.m.	Participant's classroom
Teacher H (Grade 6)	✓	✓	Dec. 10 <sup>th</sup> at 4:15 p.m.	Participant's classroom
Teacher J (Grade 3)	✓	✓	Jan. 21 at 12:55 p.m.	Room beside library
Teacher A (Grade 1)	✓	✓	Jan. 24 at 3:30 p.m.	Participant's classroom
<b>Parents</b>				
Parent A (grades 5 and graduate)	✓	✓	Nov. 14 <sup>th</sup> at 10:15 am	Participant's home
Parent B (grade 2)	✓	✓	Nov. 23 <sup>rd</sup> at 4:00 p.m.	Researcher's home
Parent C (grades K, 5 + other)	✓	✓	Nov. 28 <sup>th</sup> at 8:00 p.m.	Researcher's home
Parent D (grades 1, 3)	✓	✓	Nov. 25 <sup>th</sup> at 3:00 p.m.	Researcher's home
Parent E (grades 2, 5)	✓	✓	Jan. 9 <sup>th</sup> at noon or 2	Researcher's home
<b>Administration and Support staff</b>				
Principal (A)	✓	✓	Dec. 5 <sup>th</sup> at 9:30 a.m.	Office
Vice-Principal (A)	✓	✓	Nov. 14 <sup>th</sup> at noon	Office
Former Principal (A)	✓	✓	Dec. 12 <sup>th</sup> , 10:30 a.m.	Participant's home
Secretary (SS)	✓	✓	Nov. 15 <sup>th</sup> at 2:00 p.m.	Office

Custodian (SS)	✓	✓	Dec. 5 <sup>th</sup> at 8:00 p.m.	Library
<b>Community</b>				
PHN	✓	✓	Nov. 26 <sup>th</sup> , b/w 1-1:30	Researcher's home
FFT Coordinator	✓	✓	Jan. 14 <sup>th</sup> , 10:30 a.m.	Researcher's home
<b>Students</b>				
Student 1 (grade 5)	✓	✓	Nov. 20 <sup>th</sup> at 4 p.m.	Participant's home
Student 2 (grade 1)	✓	✓	Jan. 21 <sup>st</sup> at 10:30	Room beside library
Student 3 (grade 6)	✓ ✓	✓	Jan 30 <sup>th</sup> at 10:35	Room beside library
Student 4 (grade 4)	✓	✓	Jan. 30 <sup>th</sup> at 12:55	Room beside library
Student 5 (grade 2)	✓	✓	Jan. 9 <sup>th</sup> at 10:35 a.m.	Room beside library

## Appendix G

### The Interview Guide for Adults

(Parents, Teachers, Staff, Community members)

Thank you for meeting with me today. My name is Christa Costas-Bradstreet and I am a graduate student in the Faculty of Applied Health Sciences at Brock University. I am conducting a study that describes and analyzes the characteristics of an established health promoting school.

Because Mohawk Gardens Public School is engaging in Comprehensive School Health, you are in a unique position to share your experiences about this school as a health promoting model.

Our interview today will take approximately 45 to 60 minutes during which time I will ask you a number of questions. You do not have to answer any questions that you do not wish to answer. Further, you may end the interview at any time. You will not be identified by name. I will be using a tape recorder to record your answers. I do this so that I don't miss what you tell me and so that I don't have to take notes while we are speaking. If you would like me to stop the tape at any time, please feel free to tell me, and I will stop the tape. Within the next few days, I will present you with this interview in writing. I will ask you to read it over to ensure that you are comfortable that I have accurately captured your comments.

Once the study is complete, I hope it will be used to help other schools, school boards and health promotion agencies (such as public health departments) to implement similar Comprehensive School Health approaches at their schools. I will be leaving a report of the findings with your school's Principal if you would like to read the entire report.

Is there anything I have described that you would like me to clarify? If not, I would like to start the tape recorder and begin with the questions.

#### Questions:

- Describe what a healthy school would look like.
- Based on your description of a healthy school, how does that compare with your school?
- What does the phrase Comprehensive School Health mean to you?
- Tell me about some of the programs that you help organize or are involved with at the school

Prompts: Walk to School day? Recess boxes? Healthy eating challenges?

- What topics are addressed?

Prompts: physical activity, healthy eating

- Do you have a healthy school policy? Tell me the kinds of things it recommends.  
Prompts: fundraising ideas that do not promote food
- Look at foundations and WHO documents. What specific elements/features/components of a CSH program has this school addressed/does it address? What specific types of activities does this Comprehensive School Health program include?  
Prompt: curriculum, examples of supportive environments, etc.
- Describe how addressing these initiatives has impacted the school?
- What was the reason or reasons for becoming a Health Promoting School?
- What steps did you take to become a health promoting school?  
Prompts: form a committee, talk to the school Principal?
- Describe the ways that you communicate with parents at the school?  
Prompts: school newsletter, web site?
- Describe the ways that parents are involved.  
Prompts: volunteers, participate in healthy activities that the children take home
- Describe the ways that you communicate with community members?  
Prompts: school newsletter, web site?
- Describe the ways that community members are involved at the school.  
Prompts: volunteers, attend activities hosted at the school
- How does your initiative support teachers to improve their health?  
Prompts: healthy staff luncheons
- What barriers did you face and do you still face in implementing a Comprehensive School Health approach?  
Prompts: resistance from ...? Curriculum constraints?
- How did you address those barriers?  
Prompts: meetings, community help?
- How would you define “positive change” and success?
- Describe the feeling you get when you are at the school.  
Prompts: philosophy? Atmosphere?
- Describe your involvement with the healthy school approach?
- What are some of the keys to your school’s success?

## Appendix H

### Final: The Interview Guide for Students

Thank you for meeting with me today. My name is Christa and I am a student at Brock University. I am interested in learning more about how schools promote health. Your school is thought of as a school that promotes health in a number of different ways and that is what I would like to learn more about.

I have some questions I would like to ask you and it will take about half an hour or so. You do not have to answer any questions that you do not want to answer. There are no right or wrong answers – it is just your thoughts I am interested in. If you want to stop answering the questions, please tell me and we can stop. I will not be using your name. I will be using a tape recorder to record your answers. I do this so that I don't miss what you tell me and so that I don't have to take notes while we are speaking. If you would like me to stop the tape at any time, please feel free to tell me, and I will stop the tape. Within the next few days, I would like to read you the answers that you gave me and you can tell me if I understood what you told me.

Once I have finished asking people questions, I will share information about the school with other schools who want to do the same thing as your school is doing.

Is there anything I have said that you do not understand or you would like to ask me about? If not, I would like to start the tape recorder and begin with the questions.

#### INTERVIEW GUIDE

*Describe their understanding or views about the whole package*  
*Talk about various initiatives and ask about them.*

#### Questions:

- Would you tell me about what a healthy school looks like?  
 Prompts: does it have anything to do with the food eaten, physical activity, nice atmosphere both inside and outside
- Would you tell me about what children do at school to be healthy?  
 Prompt: as above
- What do you do to be healthy? Give examples.
- Who do you do these actions with? (Prompt: friends?)
- Where do you participate in healthy activities? (Prompt: gym, outdoors, etc.)
- When do you participate in healthy activities (Prompt: recess, during class?)

- How do these activities make you feel?
- Does your school have a special name to show everyone that it is healthy? If so, what it is? What does that mean to you?
- What kinds of activities does your school have?  
Prompts: Walk to School day? Recess boxes? Healthy eating challenges?
- What would be some reasons that your school wanted to become healthier / wanted to help the students become more healthy?
- How do you help your school to become healthier?  
Prompts: participate in activities? Help on committees, give ideas to teachers/school Principal?
- Tell me about some of the programs that you help organize or participate in at the school
- Would you tell me about any “rules” that your school has to make it healthy?
- Tell me about how your parents/caregivers/guardians know what healthy things happen at your school.  
Prompts: school newsletter, web site?
- Do your parents/caregivers/guardians participate in the activities that you do?  
Prompts: walk to school, keep food journals, etc.
- Do other people come in and help at your school?  
Prompts: grandparents, Public Health Nurse? Police? Fire fighters?
- Is being healthy a hard thing to do?
- Can you think of anything that would help you be healthier at school? At home? When you are out?
- Describe the feeling you get when you are at the school.  
Prompts: Atmosphere?
- What would you like to tell students at another school about how to make their school healthier?

## Appendix I

### Observation Prompts



Some ideas from *Creating a Healthy School*, OISE,  
<http://leo.oise.utoronto.ca/~aanderson/csh/creating.htm>

- Bright colours and welcoming entrances
- Shrubs, plants, flowers in and around outside of school
- Games painted on black top
- Bike racks near front of school where considered safe to leave
- A location to lock up in-line skates, scooters, skateboards, etc.
- Creative Playground on school property
- No Idling signs posted in / near parking lot
- Parking lot closed to cars during morning drop off and afternoon pick up
- Student bulletin boards that are colourful, appealing, attractive
- Plants, trees, fish tanks and other decorative items that make the school inviting and welcome
- Bulletin boards that recognize special students (e.g., birthdays, newcomers, student work, special achievements both inside and outside of school).
- Announcements that recognize student, staff, parent, community accomplishments. Effort is made to ensure everyone is featured in an announcement throughout the school year.
- Interactive staff meetings; recognition of staff accomplishments
- A welcoming main office and administration that encourage students to visit, as opposed to finding it intimidating. Encourage students to come down to share accomplishments
- Students take on leadership roles (intramural or recess games); participate in student-led initiatives (e.g., peer mentoring)
- Catch people doing something right
- Signs around the school saying “through these doors walk the greatest kids on earth” or “Bradstreet Public School has high expectations for all”
- “Dial a Praise” – call parents to share some good news about their child (not just negative news)
- Send each child a birthday card from staff and Principal
- Extracurricular activities – sports, music, art club, drama, etc. Participation is stressed and cuts from teams are non-existent
- Intergenerational activities – community members participate in classroom activities
- Posters, murals, signs, drawings with healthy messages
- Hand washing signs and / or pictures in the bathrooms
- Community participation initiatives such as food drive boxes, clothes collection, book round ups for donations

Appendix J:  
Coding System

Code	Obvious / Dubious / Hidden	Description
TL/TE (lime)	O	Teaching & Learning / Training for Educators
TL/TLA (green)	O	Teaching & Learning / Teaching Learning Approaches / Teacher Role
TL/CUR (bright green)	O	Teaching & Learning / Curriculum
TL/RES (teal)	O	Teaching & Learning - Resources
HSS (pink)	O	Health and Support Services
SSE/P&P/P,T,S Id: Pro or Pol (Purple, 4 <sup>th</sup> down, 1 <sup>st</sup> from R, 102,0,204)	O	Supportive Social Environments / Programs and/or Policies at school for parents, teachers, students
SSE/GR (Indigo)	O	Supportive Social Environments Government Role
SSE/SCR (pale blue)	O	Supportive Social Environments School Council Role/influence
SSE/TRM (aqua)	O	Supportive Social Environments Teacher Role-modeling
SSE /AR (lavender)	O	Supportive Social Environments Administrators' Role/influence
SSE/PR (gray – 50%)	O	Supportive Social Environments Parents role/influence
SSE/SR (Gray – 25%)	O	Supportive Social Environments Students' Role
SSE/CL (blue)	O	Supportive Social Environments Community Link
SSE/SBI	D	Supportive Social Environments / Staff buy-in (teacher supporting initiatives)
N-(tan, 153,102,0)	O	Nutrition
PA (red)	O	Physical Activity
HPE (dark red)	O	Healthy Physical Environment
C (orange)	D	Communication
■ (pink highlighter)	D	Feelings about HS
BC (violet)	D	Behaviour change
DSH (rose)	D	Definition and/or understanding of School Health
IMP (dark yellow)	D	Impetus for the initiative
■	D	Barriers and/or Challenges
■	D	Key Ingredients
■	O/D	Successes



	D	Sustainability
ADV (light orange)	D	Advice
	D	Perceived ability to influence Students
MED (25% gray)	D	Media
REL (light blue)	D	Relationships, Respect, Feelings

Related to Questions

V = vision question

MG = Mohawk Gardens and how it relates to vision

CSH = question re defining CSH

A = Awareness of MG being a HPS

TOP = topics covered

RKH = Responsibility for Kids' Health

CR = Contributing Roles

IMP = Impetus for this initiative

AC = Acceptance of Initiative

KI = Key Ingredients

SUC = Successes

PRO = Programs

CH = Challenges

SUS = Sustainability

COM = Communication

ADV = Advice

MOD = Model

O = Obvious

D = Dubious

H = Hidden